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A ‘suitable role’:

Professional identity and nursing in India

Sonali Elizabeth Johnson

Thesis submitted for the degree of Doctor of Philosophy

October 2010

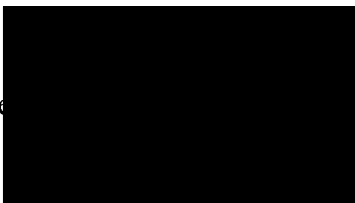
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Declaration

I, Sonali Elizabeth Johnson, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature



Date 10/03/11.....

A 'suitable role': professional identity and nursing in India

Abstract

This dissertation examines the careers and collective professional identity of nurses working in India. It analyses the impact of gender, caste and class on the decision to enter nursing, the types of career opportunities envisaged by nurses, accounts of nursing practice in hospital settings and the professionalizing strategies debated by the profession's leaders to achieve greater social and professional legitimacy for Indian nurses.

The backdrop to this study is the city of Bangalore, a quintessential example of an increasingly globalized India, commonly referred to as the country's 'Silicon Valley'. Bangalore is the site of numerous hospitals and medical facilities and has the largest concentration of nursing educational institutions in the country. As modern, urban India is increasingly characterized by the unravelling of traditional forms of social stratification, the study examines social change within the profession of nursing and its repercussions for the professional identity of nurses. The research draws upon literature from the sociology of professions as a theoretical framework and examines the relevance of these theories to the study setting so as to develop new understandings of nursing culture in a non-Western context. The findings of the study include evidence of a 'collectivist' rather than an 'individualistic' approach to career decision-making in which the presence of 'nurse families' and community networks serve as important social and professional resources. Given the traditional associations with nursing and low status work, the study demonstrates how the professional project of nursing is focused around achieving collective social mobility. The dissertation discusses the importance of migration as a professional 'asset' and highlights contemporary debates around further education and specialization as strategies to achieve greater social and economic rewards for Indian nurses.

*For my parents, Sara and Christopher Johnson
and my brother, Mark*

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List of Acronyms

ANM -	Auxiliary Nurse Midwife
BSc -	Bachelor of Science
CGFNS -	Commission on Graduates of Foreign Nursing Schools
GNM -	Diploma in General Nursing and Midwifery
INC -	Indian Nursing Council
KNC -	Karnataka Nursing Council
NCLEX -	National Council Licensure Examination
NRI -	Non-Resident Indian
OBC -	Other Backward Classes
PUC -	Pre-University Course
RN -	Registered Nurse
SC -	Scheduled Caste
SSLC -	Secondary School Leaving Certificate
ST -	Scheduled Tribe
TNAI -	Trained Nurses Association of India
WHO -	World Health Organization

Introduction

The first pieces of the puzzle

'After wannabe Bill Gates, it's Florence Nightingale clones who will go places' is the opening line of an article entitled *'Nurses: America's most wanted'* from the *Times of India* (2nd May 2005). It was the issue of nurse migration that first sparked my interest in studying Indian nurses. I was struck by the frequent appearance of articles both in the Indian and Western press with headings such as *'Nurses go west'* (*Times of India*, 19th January 2005) and *'Indian nurses' American dream'* (BBC news, 1st September 2003). While thinking about these articles, I became more intrigued by the personal histories of these nurses. Who were they? Why were they migrating?

My interest in nurses was also strengthened by a growing personal appreciation of the importance of human resources for health to creating sustainable and effective public health programmes. Prior to embarking on my doctoral studies, I worked in the area of gender and HIV/AIDS programming and policy and, in this capacity, travelled on a number of occasions to countries in Africa. My work took me to district level hospitals and clinics offering HIV/AIDS prevention, treatment and care services as well as to small community based initiatives. During these visits, I mainly interacted with members of the nursing profession who were responsible for a very large spectrum of clinical and managerial duties, such as setting up and running HIV prevention and treatment services, overseeing the treatment and care of survivors of sexual violence, training community based volunteers to work with local communities and other activities.

At the same time, I became aware of a noticeable increase in attention paid to health workforce issues in discussions related to meeting key public health targets, such as those outlined in the Millennium Development Goals (MDGs) and in efforts to scale up treatment and care for people living with HIV and AIDS. The World Health Report of 2006, for example, looked specifically at the health work force and examined ways to address key gaps in health systems through strategies such as 'task shifting' and creating new categories of auxiliary workers to work in primary health care. Not surprisingly, the issue of migration and retention of health workers, particularly physicians and nurses, featured significantly in the report and has continued to emerge as a key theme in discussions on challenges to the capacity of lower income countries to strengthen their health systems. I thus began to reflect

upon the implications of health workforce constraints and migration for the health system in India, the country where I was born and where I had long had a keen interest in conducting health systems research.

As I began to explore the topic of nurse migration in India, further questions around the nursing profession in contemporary India started to emerge. For example, I began to wonder if there is an intrinsic relationship between migration and the attractiveness of nursing as a potential career. Discussions with academics studying migration trends from India and with nurses interviewed informally as part of an initial exploratory visit to Bangalore began to support some aspects of this idea particularly for nursing students and newly qualified nurses. I also became aware of signs that indicated a generational shift between younger and older nurses, the latter of whom tended to talk about their profession in terms of a public service and as a 'calling', and who felt strongly that younger generations of nurses were mainly interested in the prospects of an international salary rather than of being 'of service' to humanity.

Another intriguing aspect that drew me towards a more in-depth exploration of Indian nurses was that almost everyone that I talked to in India about a potential study of the nursing profession seemed to have an opinion on the state of nursing and nurses in the country. These opinions were split between those who admired the work and commitment of nurses and admitted that it was a 'hard job' and those who felt that most nurses were not well educated or trained, and that nursing care in India was poor and not on a par with Western countries. Some discussions also revealed wider social attitudes towards nursing as a respectable occupation for women, particularly women from more affluent backgrounds. For my parents' generation in particular, nursing was not considered to be a suitable choice for girls from middle and upper-middle class families. For example, while reflecting upon my interest in studying Indian nurses, my mother remarked that nursing would not have been considered as an appropriate occupational choice for her. She recalled that her mother (who was reportedly very caste and class conscious) had expressly told her never to consider nursing as it was a job for girls from poorer families and too close to domestic work to be 'respectable'. Medicine, on the other hand, would have been an acceptable choice as this was seen as a prestigious profession, did not involve 'dirty work' and thus had none of the negative connotations of nursing.

Due to my Indian heritage and frequent visits to India, I was aware of some of the historical and cultural influences that underpin attitudes towards 'caste' and 'class'

appropriate work.¹ However, given reports in the international media of the rapid modernization and development of '21st century India', I began to wonder whether my grandmother's perspective still holds true. Could such an attitude be considered archaic and no longer relevant in modern India? How then, could these two images of nursing (i.e. that of the low status worker and that of the global professional) be reconciled? Consideration of this question led me to probe further into who is choosing to enter nursing today and for what reasons, as well as the social and professional position of nurses within contemporary Indian society. In addition, more specific questions around the recruitment, retention and professional responsibilities of nurses in the Indian medical system also began to emerge.

Following on from these initial thoughts and discussions, my research became oriented towards broader perceptions of professional identity among nurses in contemporary India. My decision to examine the narrative accounts of nurses was so as to be able to better understand how nurses see themselves as a collective group and to examine key features of nursing culture in India.

Why conduct this research?

Nurses are the largest group of health providers in most countries, and are seen as vital to the efficient functioning of health services. Informal discussions with academics and researchers familiar with the Indian health system conveyed to me that little research to date has been conducted on nurses in India from a human resources perspective, particularly looking at attitudes towards work and career. In order to confirm this, I conducted an initial desk based review of mainly published studies and reports. A pubmed search of 1,633 entries using the search phrase '*nursing in India*', and an examination of 433 entries with the search phrase '*nurses in India*' came up with a number of studies mainly looking at skills, quality of care as well as knowledge, attitude and practice related to a range of public health issues, including neonatal survival, maternal and child health, vaccinations, care of the elderly, HIV/AIDS, termination of pregnancy, contraception and reproductive health among others.

Reports accessed through other databases such as ELDIS were mainly concerned with international migration, and selected national programmes such as child survival with a focus mainly on community health workers. Some articles matching my research interests were found in a few nursing journals, particularly the *Nursing Journal of India* from the 1980s and

¹ These cultural attitudes are discussed in more detail in the opening chapters of this dissertation, particularly the history of nursing in India and Chapter 3 'A suitable job': becoming a nurse.

1990s and are mainly commentaries on the future direction and role of nurses and nursing education rather than research studies (Vora 1988; Prakasamma 1988; Mehra 1989; Samuel et al. 1990; Vazhapilly 1995). A number of articles published in 1978 and in the following years are focused on the role of nurses in primary health care and appear to be a reflection of the Alma Ata Declaration of 1978 to which India is a signatory (Mittal and Oberoi 1978; Swann 1984; Kurup 1984; Nambiar 1990). A handful of entries look at issues of motivation and career opportunities for nurses, as well as occupational stress (Andamuthan 1986; Makhija 2004; Supe 2000; Saxena 2001). A few recent research studies are available on Indian nurses working abroad (Dicicco-Bloom 2004; Buchan et al. 2005; George 2005; Percot 2005) as well as factors influencing the international migration of Indian nurses (Thomas 2006; Khadria 2007). Some of these studies are particularly helpful in understanding ‘push’ and ‘pull’ factors for migration.²

This initial review of available literature confirmed that there are few, if any, sociological studies that examine the interplay between historical, cultural and social factors and its effects upon the professional identity of nurses. Research in this area can contribute to knowledge about the nursing profession from a non-Western perspective as well as to wider literature on the sociology of the professions. Such a study would also be timely given that there is increased discussion from a policy perspective on the recruitment and retention of Indian nurses, including the causes and effects of recruitment to countries overseas. I was therefore particularly keen to understand decision-making around migration through examining the career possibilities and working lives of nurses currently based in Bangalore, a large metropolitan city that serves as a key exit point for many nurses heading towards jobs abroad. However, rather than being the exclusive focus of this study, migration served as an entry point towards looking at broader decision-making processes around employment in Indian hospitals in both the private and public sector, as well as to capture changing trends within the profession of nursing itself. In this respect, it is envisaged that the information generated through the research can contribute to increased understanding of the professional profiles of Indian nurses and assist in laying the groundwork for human resources policies in the health sector, particularly those relating to recruitment and retention.

² For example, a survey of 448 nurse practitioners, nurse educators and nurse administrators carried out by Thomas in 2006 found that economic factors, dissatisfaction with working conditions and unhappiness with prevalent social attitudes were identified as being of key importance for the migration of Indian nurses abroad (Thomas 2006). Other studies on migration are discussed further in Chapter 1.

Research objectives

At a broad level, the study aims to uncover characteristics that define nursing culture in contemporary India and uses the city of Bangalore as a case study. The research draws on a qualitative, 'in-depth' approach to investigate understandings of professional consciousness or 'identity' among nurses, whether and why values attached to nursing have shifted, and how Indian nurses envisage their careers in the field. The study also examines threats to the professional status of nursing and the professionalizing strategies being promoted by the nursing community to counter these and strengthen nursing's position in the health system and in wider Indian society.

The study's research objectives are:

- To understand how nurses view the nursing profession
- To investigate factors leading to nursing as a career choice
- To understand career pathways and how these are constructed
- To understand conceptions of professional identity in nursing
- To contribute to knowledge of the sociology of the profession

Welcome to Bangalore!

This study was undertaken in the city of Bengaluru (Bangalore)³ in the state of Karnataka, south India. Karnataka is located in the southern part of India and is the ninth largest state among India's twenty-eight states and union territories. It borders Maharashtra and Goa in the North, Andhra Pradesh to the east and Tamil Nadu and Kerala to the south and in the western part, forms part of the Arabian Sea coast. As of the 2001 census, the population in Karnataka was 53 million and accounts for 5.13% of India's population (Government of Karnataka 2006). It is composed of 27 districts. Although Kannada is the official language, other languages commonly spoken include Telugu, Tamil, Hindi and English. It is therefore not uncommon for a Bangalore resident to speak three or four Indian languages in addition to English.

³ In 2007, Bengaluru became the official name of the state capital of Karnataka and marks a return to the original Kannada name of the city. However 'Bangalore', the anglicized version, is still widely in use and consequently, I refer to the city as 'Bangalore' in this thesis.

Bangalore is situated on the Deccan plateau in the south-eastern part of Karnataka state and is the state capital. It has an estimated population of 6.5 million and is the third largest city in India. Bangalore can perhaps best be described as being in a state of constant change. Over the last twenty years, the city has undergone an enormous transformation in which outlying suburbs have been brought under the remit of the city corporation of Bangalore (the Bruhat Bengaluru Mahanagara Palike) commonly referred to by 'Bangaloreans' as the BBMP. A large number of infrastructural projects are being undertaken throughout the city which include the construction of a city metro, new roads and motorways, bridges and other public works.

Bangalore is divided into two districts: Urban Bangalore and Rural Bangalore, but the majority of the city lies in the urban district. Like Karnataka and most of India, Bangalore is home to people of diverse cultures, languages and faiths. According to the 2001 census, 79% of the population is Hindu and 13% is Muslim, where this is similar to the national average. However, the Christian and Jain communities make up approximately 5.8% and 1% respectively, which is double that of the national average (Government of India 2001).

Like other Indian cities, Bangalore is a city of paradoxes. Although the slums are not as visible as in other Indian metropolises such as Mumbai, a visitor to Bangalore will take in a huge range of architectural styles, from modern apartment buildings, 'designer' hotels and gated communities of luxury villas to tiny roadside shops, temples and crumbling buildings framing narrow lanes. New shopping malls continue to spring up all over the city, housing multiplex cinemas, foreign brand shops, restaurants and cafes. However, the crowded markets of 'old Bangalore' still remain with their stalls selling fruit and vegetables, clothes, books, furniture and other household utensils, attracting both residents and tourists to the tiny and chaotic streets.

Living, working (and researching!) in Bangalore for frustrated residents involves nightmarish traffic jams, roads being constantly dug up and re-laid, and frequent power cuts. At the same time, there is a palpable sense of excitement in the city, as if Bangalore is at the frontlines of modern India. From the sleepy city of parks and lakes I remember from my childhood, Bangalore is fast becoming a large metropolis with a growing middle class and legions of students, who are the main clients of the malls and restaurants and the intended targets of the real estate explosion. Over the past years, Bangalore has become synonymous with the 'IT' Information Technology boom in India and is known as India's 'silicon valley'. The city has therefore attracted 'tecchies' (as they are commonly referred to in the Indian

media) from all over India, many of whom work in the large 'Technology Parks' that are found in different parts of Bangalore. Due to its range of medical and research facilities, including 'super-speciality' hospitals⁴ and bio-technology companies, Bangalore is considered to be a major medical hub in India, as well as a recruitment hub for health workers, including nurses (Khadria 2004).

An inevitable constraint in conducting research in India is that due to the huge diversity of the country, it is unlikely that research in any one region can be seen as representative of India as a whole. With its mix of cultures, religions, regional languages and ethnic groups, building up a representative picture is a very difficult undertaking and would entail multi site research over a much longer period of time. This was not possible with this study. On the other hand, Bangalore is a migratory destination for people coming from various parts of India, and consequently provides an excellent location in which to examine the complex fabric of Indian society. In addition, students who train in Bangalore's nursing schools and hospitals come from surrounding southern states such as Kerala and Tamil Nadu, and therefore the research can provide a good idea of nursing culture in the south of the country.

Introduction to the Indian health system

India's health system is complex and characterized by different systems of medicine (Allopathy, Ayurveda, Unnani, Sidda and Homoeopathy) and patterns of ownership (public and private services). Constitutionally, health care delivery in India is largely the responsibility of provincial states. The central government, through the Ministry of Health and Family Welfare, is in charge of defining national policies and providing a national strategic framework, implementing national public health and disease control programmes as well as overseeing medical education. In 1992, amendments were made to the Indian Constitution that required Indian states to delegate some administrative authority to local or village (Panchayat) bodies.⁵ Consequently, state and local governments incur about three-quarters of public spending on health, with one-quarter covered by the central government.

Public health services are predominantly delivered through a tiered network of sub-centres, primary health care centres, community health centres and district hospitals. In rural

⁴ This is a term commonly used in India to describe multi-speciality tertiary care hospitals that offer advanced procedures and use 'state of the art' equipment.

⁵ This delegation of administrative authority to village councils is known as the Panchayati Raj Act.

areas, most primary health care (PHC) is provided by sub-centres or primary health care centres, whereas in urban areas PHC services are available in health posts and family welfare centres. Recent reforms of the health system include further decentralization of health care services, increased public-private partnerships and financial reform. In 2005, the Indian government introduced the National Rural Health Mission (2005 - 2012) to improve availability of and access to quality health care for those residing in rural areas, with particular emphasis on the poor, women and children.

The private health sector consists of 'not-for-profit' and 'for-profit' health facilities. The not-for-profit health services include those run by non-governmental organizations (NGOs), missions and charitable institutions and range from small nursing homes and outpatient clinics to multi-speciality hospitals. 'For-profit' services include privately operated clinics and nursing homes, pharmacies and corporate hospitals. The private health sector is largely unregulated and includes licensed personnel such as general practitioners (GPs), consultants, registered nurses, auxiliary nurse midwives (ANMs), paramedics and rural medical practitioners (RMPs) as well as practitioners with little or no formal qualifications such as faith healers, local medicine men / women, traditional birth attendants, and a variety of unqualified persons or 'quacks' as they are referred to in the Indian media.

Although public services are available throughout the country from primary health centres to multi-speciality hospitals, most visits to health providers are to those in the private sector. Reasons for the high use of private health services, including by the poor, are mainly due to access and availability. Studies that have looked at use of private versus public services amongst the poor in India have found that users, particularly in rural areas, complain that public services are located too far away, the hours are irregular and doctors and other service staff are not always available (Radwan 2005). Although public services are meant to be provided free of charge, this is not entirely the case as there are often costs associated with treatment as well as indirect costs such as transportation and lost wages. In some cases, therefore, the cumulative cost of accessing a public sector facility can outweigh the costs of a conveniently located private clinic.

There are, however, a number of concerns around the provision of private health services in the country. These concerns are particularly related to the lack of proper accreditation and background checks of health personnel as well as insufficient data on the number and types of providers, services and fees levied in the sector. The 57th round of the NSS (National Sample Survey) on Unorganised Service Sector Enterprises in India conducted

in 2001 - 2002, revealed that more than one-third of health enterprises do not have any form of registration (Rao et al. 2005). Therefore, in the absence of regulations governing location, standards, pricing and so on, private providers have the freedom to provide any kind of service, of whatever quality and cost (Bhat 1996, 1999; Rao et al. 2005). At the same time, contracting private services has emerged as a new trend in public sector management to increase access, efficiency and responsiveness to users (World Bank 2004). Contracting of private services by the public health sector is diverse and ranges from laundry services, catering and hospital management, to diagnostic and clinical services. Public-private partnerships are also being encouraged by the Indian government in the delivery of health care. For example, in order to meet its objectives in providing primary health care particularly in rural areas, the government has contracted a number of NGOs to provide training to public service health staff, as well as running some primary health centres (PHCs).

As in other parts of India, Karnataka has a mix of private and public health services. However, the use of private health services across southern India is higher than that of public services. According to the NSS survey data, among the southern states, rural Kerala has the highest proportion of cases treated in government hospitals followed by rural Karnataka (Government of Karnataka 2006). However, in urban areas in Karnataka, the number of cases treated in government facilities is the lowest across all southern states and all India (Government of Karnataka 2006).

The research sites

Bangalore's *mélange* of private and government run health facilities, as well as nursing schools and colleges provides a rich sample of research sites. The size and profiles of hospitals in the city also varies widely, from the top-notch private hospitals catering to wealthy Indian and foreign clients to 'hole in the wall' private clinics, to government hospitals catering to lower income patients from Bangalore and surrounding areas. Interviews were conducted across six different sites so as to reflect the diversity of health facilities in the city and to include the perspectives of nurses working in different settings.

Of the six sites from which data was collected, three were private hospitals, one was a private outpatient clinic and two were government hospitals. Site 1 is a cardio-thoracic unit within a large multi-speciality 'high end' private hospital (1,000-plus beds) and functions as an autonomous unit within the hospital. Site 2 is a private multi-speciality teaching hospital

(1,000-plus beds) that caters to lower income patients and situated not far from site 1.⁶ Site 3 is a private multi-speciality mission hospital (1,000-plus beds) that caters to middle-class and poor patients.⁷ Like Site 2, it also functions as a teaching hospital and has its own medical and nursing school. Site 4 is a modern ‘high end’ private outpatient clinic that caters mainly to middle and upper middle class patients. The clinic also offers tele-radiology services to hospitals based in the United States and in Asia. Site 5 is a large (1,000-plus beds) central government hospital that provides specialized psychiatric and neurological care and caters to a wide segment of the population. Site 6 is a Karnataka state government hospital (500-plus beds) offering maternity, gynaecological and paediatric services. In addition to the hospitals above, I also visited two private nursing colleges in Bangalore and was able to interact with staff and students at these sites.

I have deliberately not mentioned the names of these hospitals and refer to them throughout the thesis by their ‘site’ number to safeguard the identities of the nurses interviewed. However, I am aware that to anyone knowledgeable about Bangalore, the names of some of the sites may be easy to guess. At the same time, given the large size of the hospitals and the small sample of nurses interviewed within each, it would be very difficult to identify individual nurses from their testimonies. As will be seen in the table included in Appendix 9, each nurse interviewed in this study has been given a pseudonym.

A brief history of nursing in India

Traditionally, the work of women in India outside the home was mainly in the informal and unregulated ‘craft’ and agricultural sectors. With the gradual expansion of female education in the late 19th century, access to professional training in the areas of nursing and teaching provided women with the possibility of an independent income. Nursing and teaching were the first occupational choices available to women that gave them access to an independent income and became a particularly important source of employment for those who were widowed, orphaned or unsupported financially. In contemporary India, nursing has

⁶ During a visit to Site 2 in December 2009, I observed extensive renovations within this hospital and the construction of a new building. Newspaper reports indicate that the hospital’s ICUs, OTs and wards will be renovated including the replacement of medical equipment. Although it is likely that there may be some increase in the costs of care provided, the articles indicate that tariffs would not be increased significantly and that government subsidies continue to finance the care of patients below the poverty line.

⁷ Treatment of the poor is supported through special tariffs and government subsidies.

remained a key occupation for women; a number of nurses told me that they considered few other options and went directly into nursing after school.

Looking at the historical development of nursing in India provides a great deal of insight into contemporary attitudes and perspectives. Consequently, a brief history of nursing in the sub-continent is included here as background for the reader. Although the colonial period is perhaps more significant in its relationship with modern forms of nursing in India than accounts of nursing in antiquity, I do not wish to portray the nursing profession in India as an entirely ‘Western’ occupation. Therefore, the following section begins by briefly outlining what is known regarding the origins of nursing in ancient India.

Nursing in ancient India

Very limited information is available regarding nursing in ancient India. References to nursing work can be found in two ancient medical treatises that were the foundation of the ayurvedic system of medical care in India - the Caraksamhita and the Susrutasamhita. There is some debate as to the dates of the composition of these texts but they are thought to originate from between 600 BC and 100 AD. Leslie and Wujastyk (1991), who have examined these texts in detail to understand nursing practice in ancient India, argue that parallels with modern day nursing need to be made with caution as in both texts, nurses are seen as doctors’ ‘assistants’ rather than practitioners in their own right. However, both the Caraksamhita and Susrutasamhita provide information on the tasks required of these assistants. In the Caraksamhita, some of the tasks of the paricarakan (assistants) are identified as those that assist the infirm with daily activities. According to Leslie and Wujastyk:

For example, they should be able to prepare pulses or soups, to cook rice, to give baths (snapaka) and massages (samvahaka), to lift patients (utthapaka) and help them lie down again (samvahaka), and to grind the necessary herbs for drugs (ausadhapesakams ca). (Leslie and Wujastyk 1991: 27)

In the Susrutasamhita, tasks performed particularly by female attendants are related to their work as midwives and wet nurses. The ‘ideal’ characteristics of these assistants are provided in both treatises. As Leslie and Wujastyk write:

According to Sus.Su.34.15 and 24, assistants (paricara) should be trained to help the doctor or surgeon in treating the patient, and they should tend the patient throughout his illness, remaining always by his bedside. Such an assistant should be friendly

(snigdha), non-critical (ajugupsur), physically strong (balavan), good at caring for the sick (yukto vyadhitarakshane), obedient to the doctor's orders (vaidyavakyarkrd), and tireless (asranta). (Leslie and Wujastyk 1991: 28)

It appears that nursing care was provided to members of the same sex, with women attending to women and men attending to men. Doctors, however, were male (Leslie and Wujastyk 1991).

Much of the public nursing carried out in the ancient period came about as a consequence of the strong influence of Buddhism in India. During the time of King Ashoka (272 BC - 232 BC), a convert to Buddhism, hospitals were built to take care of both sick people and animals. Medicine was given great importance with medical schools established at Taxila and Nalanda in Bihar and the introduction of a public health system (Jaggi 2000).

However, with the decline of Buddhism and the resurgence of Hinduism, some of the last public hospitals disappeared around 1100 AD. With the dominance of Hinduism, a rigid caste structure emerged with an emphasis on hierarchy and a detailed pollution index indicating what could or could not be eaten or touched (Somjee 1991). Very little information exists on the practice of medicine and nursing until around the 15th century with the arrival of the Portuguese in India. It appears however, that much of nursing had moved from the public domain into the private domain of the family with care provided to those of the same sex. Nursing services were also most likely split into 'caste functions' that were predominantly performed by those within the lower castes (Somjee 1991). One of the oldest forms of nursing for women is that of the traditional birth attendant or 'dai', whose work continues today in contemporary India.

Nursing during the colonial period - the missionary influence

The emergence of Western nursing in India came about through the introduction of missionary medicine to the subcontinent along with the expansion of European trading routes. Christian missionaries arrived in India as early as the 15th century along with Portuguese traders and continued with the establishment of other European settlements including those affiliated to the East India Company. Although some dispensaries were set up in the new European settlements by various religious orders to minister to the sick and needy, conversion to the Christian faith was the main focus of missionary work.

With the growth of Protestant missions, the importance of medicine to missionary activities became more pronounced. This also reflected changes in the Protestant mission world, where missionaries increasingly held university degrees and a number of whom were trained in medicine. Therefore, medical missionaries, mainly from Britain and the United States, began to arrive in India from around the 1830s onwards. These 'medical missions' are consequently the focus of some notable historical studies of medicine and nursing in colonial India (see Abraham 1997; Fitzgerald 1997). As Meera Abraham writes in *Religion, Caste and Gender: Missionaries and nursing history in South India*:

Philanthropy became part of evangelical attitudes at that time and this made the role of the medical missionary much more acceptable ... The care for the body went hand in hand with the care for the soul. Whereas the early 'doctor' accompanied missionaries in order to look after them, the medical missionary became by the end of the nineteenth century "representative of all that was most admired in the later stage of the modern missionary movement. (Abraham 1996: 6)

By the end of the 19th century, the main categories of hospitals in India were military hospitals, civilian hospitals, and hospitals run by European religious missions. Nursing care in the military hospitals was provided by wives or widows of military personnel or by nurses sent out from Britain. These female nurses replaced male soldiers who were initially providing nursing care. However, the military hospitals mainly catered to the needs of army units attached to companies such as the East India Company as well as domiciled Europeans. Therefore, they are not considered by scholars to be as significant to the training of Indian nurses compared with missionary and to a lesser extent, civilian hospitals (Abraham 1996; Fitzgerald 1997; Nair and Healey 2006). Rosemary Fitzgerald, in her study of female medical missions in India, argues that the rise of the female medical missions in the late 19th century was an important turning point for the provision of health care to Indian women and children outside the 'zenana' (restricted female quarters of the household) through the construction of mission hospitals for women (Fitzgerald 1997). Fitzgerald notes that even when government health services for women were being expanded in the 1920s, mission hospitals for women represented over half of all women's hospitals in India (Fitzgerald 1997). As mission hospitals had fewer resources to recruit foreign staff, with the exception of senior nursing sisters who came from Europe and North America, local Indian nurses were recruited as nursing staff. Consequently, the bulk of the training of Indian nurses took place in mission hospitals overseen by missionary nurses. Fitzgerald writes:

Although the woman doctor still took precedence in the hierarchy of the female medical mission, the rising numbers of fully trained missionary nurses arriving in the first decade of this century could feel confident that there was a widely expressed need for the trained nurse and an increasing appreciation of her services ... Paramount importance was attached to the need for missionary nurses to develop the training for Indian women and to lay the basis of an Indian nursing profession modelled on the styles and standards of nursing in the West. (Fitzgerald 1997: 75)

From the mid-19th century onwards, the British colonial authorities had begun to develop a public health system through setting up civilian hospitals. The colonial government and medical missions became greatly concerned about the maternal health of Indian women due to very elevated levels of infant and maternal mortality. They were particularly critical of the care provided to pregnant women by traditional birth attendants or dais, which they felt was primitive and barbaric (Lang 2005). According to Hindu tradition, women in childbirth were considered impure, and were therefore tended to by the dai, who was traditionally a woman of low caste. Strict rules around male-female interaction meant that male birth attendants were not permitted for upper-class Hindus and any assistance by European doctors and midwives through home deliveries would have been very difficult as they rarely gained access to the women's quarters in Indian homes. Consequently, the work of the female medical missions was also to gain access to this restricted female domain to put an end to 'native midwifery' and to introduce Christian theology (Fitzgerald 1997).

'Lying-in hospitals' were set up in Calcutta and Madras in the late 1840s to promote Western midwifery practices. Patients in the lying-in hospitals were mainly Indian Christians and lower caste Hindu women, although they also included some women from the European and Anglo-Indian communities, who were very often army wives. Very few higher caste Hindus and Muslim women visited these hospitals, due to strict rules governing contact with the opposite sex, interaction with the lower castes as well as concerns over overcrowding and conditions at the hospital. Midwifery was the emphasis of nursing training at these hospitals with general nursing relegated to the background and considered lower status until the early 1870s, after which time a combined and expanded training in nursing and midwifery was introduced. Both male and female students were to be admitted for midwifery training, although it was expected that the majority of applicants be wives or widows of soldiers from the British regiments, Anglo-Indians, Parsees and to a lesser extent, Indian Christians. An attempt was made to recruit higher caste women to the nursing profession so as to encourage the attendance of high caste Hindu women at these hospitals, but these efforts met with

resistance by the Brahmin community due to the traditional association between midwifery/nursing and persons of low caste (Abraham 1996).

The entry of Indian women into nursing in missionary hospitals was also facilitated by the spread of female education by the Protestant missions in India. Mission schools were initially set up for the Christian convert community, although the numbers of Hindu and Muslim pupils increased from the 1930s onwards (Abraham 1996). Converts to Christianity were typically those from lower castes, untouchables (those outside the caste system) and orphans. Most of the mission schools taught in English in addition to local languages and followed a European curriculum. Young women graduating from these mission schools were particularly able to access two careers available to women at that time - teaching and medicine (mainly nursing). As the caste hierarchy was not so visible in Christianity, these converts were also not as affected by fears of pollution and other caste constraints found in Hinduism. Therefore, many of these women went straight into working in the missionary hospitals. However, the affiliation of low caste Hindus and Christian converts with nursing made those from higher Hindu castes reluctant to take up nursing training. This presented a challenge to the female medical missionaries and nurses working in India at that time, who sought to recruit those from upper class and caste Indian backgrounds to lift the public image of nursing (Nair and Healey 2006).

Historical issues in contemporary India

Although it may seem unusual that many of the key figures in nursing history of India are 'foreign', this is to be expected given the dominance of Western medicine on the health care system in India from the 19th century onwards. Writing on the imperialist intentions of the US in the Philippines through the promotion of medicine and nursing, Choy (2003) subjects this 'humanitarian' work by the Colonial authorities and their representatives, to a thorough critique. Choy writes:

Unlike other economic, political, and educational agendas in the colony, the popular conceptualisation of Western medicine as a universal humanitarian effort to save lives continues to make it difficult for scholars and others to critique its racialized and gendered social hierarchies. (Choy 2003: 19)

Choy also argues that medicine was part of the race for empire, where medicine's 'power to heal' and the justifications for domination over the colonized are inextricably linked (Choy

2003).

Many of the pioneer Indian nurses did not share the influence of their European sisters on the direction and content of nursing in India until after Independence in 1947. Indeed, membership of the Trained Nurses Association of India (TNAI) formed in 1908 was almost exclusively composed of European nurses, where the position of President was only taken over by an Indian nurse after Independence (The Board of Nursing Education Nurses League 2004). However, the transfer of leadership in nursing began to change in the years leading to Independence, through increasing numbers of Indian nurses on the faculty in nursing schools and in nursing boards and committees.

It is also important to mention here the work of Indian social reformers during the 19th and 20th centuries, the majority of whom were from the Brahmin caste and included a number of key female figures. Pandita Ramabai (1858 - 1922) for instance, was a Brahmin who advocated for female education and the entry of Indian women into professions such as medicine and nursing (see Kumar 1993). Other important male and female reformers were attached to the various waves of Indian reformist movements in the 19th and 20th centuries such as the Arya Samaj and the Brahmo Samaj. These sought an end to Hindu practices such as child marriage and 'sati' (widow burning), and promoted widow remarriage and female education. Although there were counter movements to these, the 19th century saw the beginning of debates around religious and social customs for both Hindus and Muslims that were very much centred on the status and rights of Indian women and assisted the entry of Indian women into the public workplace.

A number of historical influences are present in nursing in the modern Indian context. Firstly, the Christian influence on nursing continues to be felt today, where the language of nursing has strong Christian overtones and is based on the notion of Christian 'Sisterhood'. Missions such as the Nurses League of the Christian Medical Association of India (CMAI) continue to be greatly involved with boards of nursing education and, in the decades following Independence, Christian and Anglo-Indian women mainly took up the profession. There is evidence that this is changing, with nursing students being increasingly drawn from other communities (particularly Muslim and Hindu). Consequently, this changing profile of Indian nurses will be explored in greater depth through the study. Secondly, the importance given to midwifery during the colonial period is reflected today in the combined training in nursing and midwifery for Indian nurses. In some areas, particularly in rural India, female health providers remain critical in providing health care where there is strict seclusion of

women. Therefore, training in midwifery in nursing programmes reflects both a historical and current public health need. Thirdly, the association between nursing and low status work is one that has endured in India. For women of different faiths, entering a 'public' profession such as nursing and breaking with traditional Indian social norms where women are provided for by male relatives, has risked acquiring a social label of 'loose' and 'immoral' in that their work takes them outside the protective walls of the home and into contact with men (Somjee 1991; George 2005). In addition, its close association with the 'body' and to 'dirty work' has contributed to the notion of nursing as a low and undesirable profession. Again, there are many signs that the image of nursing is changing - evidenced particularly by the increasing recruitment of higher caste Hindu and Muslim women and men into the profession. Nevertheless, this is a topic that is frequently mentioned as a 'challenge' and one that is investigated further in this study.

Nurse training and organization

By the early 20th century, the North India United Board of Nurses Examiners for Mission and Other Hospitals was formed, followed by the creation of similar boards of nursing in the south of the country. These boards developed the standards of nursing training, curriculum and examination with the first nursing examination held in 1910. The minimum duration of general training in nursing was set at three years, with an additional year in midwifery.

There are currently two main levels of nursing education in India. At the first level are two programmes that designate the qualification of Registered Nurse and Midwife (R.N & R.M). These are a three-year diploma course in General nursing and Midwifery (GNM) and a four-year BSc degree in Nursing. There is no separate qualification of 'midwife' in India where, as highlighted earlier, midwifery and nursing is combined in nursing education. Registered nurses with both GNM and BSc qualifications are required to undertake clinical rotations in maternity wards as part of their training and conduct antenatal care and deliveries as staff nurses. At the second level is a one and a half year training for auxiliary nurses and midwives (ANMs) that is particularly geared towards care provision in rural areas to women, children and the elderly. The Indian Nursing Council (INC) has recently announced plans to launch a new category of Nurse Practitioner in Midwifery.

Nursing schools typically offer the diploma and ANM programmes while nursing colleges offer both the BSc and diploma degree. Entry into BSc and GNM nursing requires obtaining the Secondary School Leaving Certificate (SSLC) undertaken after 5 years of secondary school, plus two years of pre-university courses (PU) that permit entry into higher education. Candidates for nursing programmes are typically required to have taken science subjects such as physics, chemistry and biology for their SSLC and PU examinations, although some colleges accept candidates for the GNM course with Arts and Commerce subjects. Candidates for the ANM course require a SSLC certificate and, upon passing the required examinations set by the Nursing Examination Board, are registered with the Indian Nursing Council as an ANM (R.ANM).

In addition, a two-year post basic (diploma/certificate) course is also available to upgrade GNM qualifications to that of the BSc nursing qualification. Diploma courses in clinical specialities, administration, education and BSc nursing are also available in various hospitals and nursing colleges across India. Postgraduate programmes including MSc and M.Phil degrees in nursing and doctoral programmes are offered in a number of nursing colleges that are affiliated with universities. This study looks specifically at Diploma and BSc nurses, and does not cover ANM nursing personnel, particularly as this category of health worker is more commonly part of primary health care provision in rural areas.

The Indian nursing council was established in 1949 to set a uniform standard of education for nurses. Each state has a nursing council and all categories of nurses are registered with the state where they undertook their nursing training. The training of nurses and ANMs is largely controlled by the state councils who also inspect and accredit schools of nursing in their state, conduct examinations and set disciplinary procedures. In addition to the state nursing council, representatives of different nursing associations such as the Trained Nurses Association of India (TNAI)⁸ are also found throughout India, with a branch in Bangalore. Other notable nursing associations include the Nurses' League of the Christian Medical Association of India, the Catholic Nurses' Guild of India and the Nursing Research Society of India.

⁸ The TNAI also manages the *Nursing Journal of India*, one of the principal nursing journals in the country.

Outline of the thesis

The following thesis begins with an examination in Chapter 1 of the theoretical literature that underpins the conceptual framework of this study - notably theories and concepts on the sociology of the 'professions', including the sociology of nursing. In Chapter 2, I discuss some of the theoretical considerations that informed the choice of study design and the methodological decisions made during the course of data collection and analysis. In this chapter, I describe the natural history of the research project, examine issues regarding access to the research participants and reflect upon my status as researcher in relation to the study participants.

In Chapter 3, entitled *A 'suitable job': becoming a nurse*, I discuss the gender, caste and class factors that designate nursing as a 'suitable job'. The chapter highlights the development of 'nurse families' in which a number of family members, often across generations, are selecting nursing training. The chapter explores the various incentives that contribute to the view of nursing as a 'job with prospects', including economic incentives and social rewards, such as the ability to earn an income in India and abroad. The chapter also looks at discourses around nursing as a 'noble profession' and examines the influence of vocational perspectives that inspired some of the participants to become nurses.

Chapter 4 on *Career pathways in nursing* examines how nursing careers are constructed within the study setting, starting with nursing education and the choice between a GNM or BSc nursing programme. The chapter highlights decision-making around the setting of nursing work, including the choice of clinical speciality, the choice of clinical setting (Ward/ICU/Operation Theatre) and the institutional context (public versus private sector). As migration is a key career strategy for a number of nurses, this chapter examines reasons for migration in detail, including the profiles of potential migrants. As Keralite nurses are often associated with the image of nurse migrants from India, the testimonies of Keralite nurses are compared with those of nurses from other states who participated in the study. The chapter ends by looking at the influence of personal and professional networks in making career choices and how these are utilized.

In Chapter 5 on *Nurses at work: managing professional relationships*, I use observational data and the interview narratives to discuss the construction of 'boundaries' between nursing and medicine. The chapter examines the key conditions of the work environment that were found to influence the professional autonomy of nurses and the

realization of boundaries 'in situ'. Given the importance laid upon the therapeutic benefits of 'emotional labour' to nursing practice, the chapter discusses the broader function of emotional labour to nurses' management of their working lives. As nurses typically utilized vocational narratives in their depictions of nursing, the chapter also examines depictions of nursing work through the telling of 'moral accounts', including 'Nightingale stories' in which nurses present accounts of their interaction with patients.

Chapter 6, entitled *Convince your patients and you will convince society: collective social mobility and the professional project of Indian nursing* highlights the professionalizing strategies debated within the professional movement of nursing in the study setting and discusses how these are focused around improving the social identity of nurses. The chapter examines the various tensions regarding the desired future direction of nursing in India and the repercussions of these tensions for the notion of a collective professional identity.

In Chapter 7, I discuss the implications of the research findings for the study of the professions. In the concluding chapter of the thesis, I outline some policy recommendations based on the results of this research study. Tables and study materials used in the research can be found in the appendices.

Chapter 1

Nursing and the contours of professional identity

This thesis examines the careers and professional identity of Indian nurses. At the time of the research, few in-depth sociological studies had been undertaken on the medical professions, including the profession of nursing, in India. The study therefore makes a contribution to global knowledge on the sociology of the ‘professions’, offering a glimpse into contemporary nursing culture in a country undergoing vast social and economic changes.

Theoretical inspiration was drawn from literature within the social sciences, particularly studies in medical sociology and nursing, in order to analyse and situate the findings of the research within broader theories around the ‘professionalization’ of health occupations and factors contributing to professional identity. The following chapter will briefly outline the main studies reviewed to develop the conceptual framework of the study, notably those found within literature on the medical ‘professions’. Rather than being a comprehensive overview of how professions are defined and organized, the chapter outlines key concepts and theories that underpin the analysis of the data and which are further discussed in relation to the research findings in the ‘Discussion’ chapter.

A problem of social status: studies on nursing from South Asia

Available literature on nurses in India can be divided along two broad themes. One theme is predominantly historical and examines the development of nursing as part of the expansion of Western medicine during India’s colonial history (Somjee 1991; Abraham 1996; Fitzgerald 1997; Nair and Healey 2006). The other has a contemporary focus and is characterized by the study of Indian nurses within the context of international nurse migration (Khadria 2004, 2007; George 2005; Percot 2005; Nair and Percot 2006). Where much of this literature meets is in the discussion around the social status of nurses in Indian society. For example, studies tracing the history of nursing frequently examine the cultural context that has given rise to the historically low social position of Indian nurses through analysing the effects of religion, caste and class on notions of appropriate work for women (Somjee 1991; Abraham 1996). A few qualitative studies on the migration of Indian nurses also engage with historical precedents contributing to nurses’ social status and contend that migration is a ‘life strategy’ for nurses and a means of vertical social mobility (Percot 2005; Nair and Percot

2006) or has resulted in a transformation of traditional gender relations within communities and households (George 2005). This research project builds upon these studies to explore the extent to which the social identity attributed to nurses by wider society contributes to understandings of a collective *professional* identity, a topic that has hitherto received little research attention.

In her book *Behind the screens: nursing, somology and the problem of the body* (1991) Jocalyn Lawler highlights the ways in which nursing has historically been viewed by other health professions and the public as 'dirty work' due to nurses' intimate handling of patients' bodies. Lawler's important study examines the 'taken for granted' nature of nursing practice and provides a frank and in-depth discussion of the complexities and skill involved in the provision of care. Her discussion of the *problem* of the body and its effects upon attitudes towards nursing work has great relevance to understanding the public image of nursing in other settings and, importantly, the ways in which nurses perceive nursing work. Studies from India, as well as from other countries in Asia and the Middle East, demonstrate how nursing is typically perceived as synonymous with 'dirty work' and domestic labour and consequently, given low social value (Somjee 1991; French et al. 1994; Lai et al. 2006; George 2005; Shuriquie et al. 2007). In her study of immigrant nurses from Kerala, Sheba George illustrates how there is a general perception of nursing as including tasks that are typically undertaken by servants in Indian households, a perception that was shared by some of the nurses she interviewed. George writes:

Mrs Jacob, who went into nursing against her family's will, described why nursing was not acceptable to her family: "In those days nurses were looked down upon, especially the nurse who went to Bombay for school. They were the ones who were doing menial work." When asked what was menial about the work, she replied, "Probably the daily activities and care for other people - cleaning them, bathing them, and things like that. At home you have servants to do things like that, and in nursing school you are doing the same thing your servants do for you ... My father was somewhat of a prominent person, and he was a Panchayat⁹ member. So it had more to do with his dignity that one of his daughters went for nursing and did not go to college. (George 2005:47)

In order to understand the relationship between nursing and socially undesirable work in India, it is helpful to examine the larger context of intersecting gender, class and racial relations that have acted upon the history of nursing particularly in former colonial settings (Marks 1994; Nair and Healey 2006). For instance, in her work '*Divided Sisterhood*' that

⁹ Panchayats are local government councils at village or small town level.

recounts the history of nursing in South Africa, Shula Marks describes how nursing's white elite promoted the profession as one for educated, middle class (white) women. However, Marks adds that in South Africa this was 'complicated' by the widespread association of nursing with menial duties such as cleaning and scrubbing "*with black rather than white hands*" (Marks 1994: 9). In the late 19th and early 20th century therefore, white and Afrikaner nurses oversaw the work of black nursing assistants, orderlies and servants in both white and black wards who carried out such tasks (Marks 1994). However, Marks points out that in 20th century South Africa, nursing became one of the most prestigious occupations for black women despite its earlier concerns around notions of racial purity, thus creating something of a paradox in the nursing history of the country.

Nursing also developed along racial lines in India, in that Indian nurses who were trained by white, middle class women predominantly provided care to the 'native' population and white patients could expect to receive care from white nurses. However, rather than race, historical and cultural norms around 'caste appropriate' work appear to be more relevant to understanding the low status attributed to nursing in the Indian context (Somjee 1991; Abraham 1996; Nair and Healey 2006). Unlike South Africa, with the departure of the British from India, the racially segregated system of care disappeared and Indian nurses predominantly provided care to other Indians. At the same time, the 'caste segregated' division of labour that has historically characterized the social fabric of Indian society remained firmly in place, in which menial work such as 'cleaning and scrubbing' and providing care to diseased bodies was seen as belonging to the low castes and 'untouchables'. As alluded to earlier in the previous chapter, concerns around providing physical care to the bodies of others is tainted by traditional caste prejudices in South Asia, in which such forms of labour were seen as exclusively the preserve of the lowest rungs of the Hindu caste system.

Two of the key characteristics of the caste system in India are the notion of 'purity' and that of 'pollution'. Purity and pollution are denoted by the caste into which an individual is born and/or occupations and practices that are considered as pure or defiling. Tasks or occupations that are considered as polluting include the handling of leather or dead animals and the removal of human waste. For those of a high caste, maintaining ritual purity involves observing caste practices such as vegetarianism and avoiding bodily fluids such as saliva, faeces and menstrual blood.¹⁰ Nursing was therefore an 'unrespectable' occupation for high

¹⁰ For example, according to Hindu custom, menstruating women are not permitted to worship at temples or cook food.

caste women due to the ritual impurity of nursing work and the risk of caste pollution.¹¹ In their discussion of nursing training in colonial India, Nair and Healey describe how the reluctance to take on the types of duties expected of nurses was largely due to the social stigma attached to these tasks and, consequently, characterized difficulties in training Indian nurse recruits:

Most detailed accounts of the education of Indian nursing students during this period discuss the difficulty of persuading Indian students to attend to the personal care of patients. Disputes were frequent between western nurses, who strongly felt that the nobility of nursing lay in a willingness to tend to every need of the human body, and their Indian students, who often felt that their experience of life within the hospital and society would be much easier if bedpans and baths could be delegated to sweepers and ward-boys. (Nair and Healey 2006: 12)

As Geeta Somjee argues, caste pollution was not just a concern of female nurses, as even male nurses were seen as doing undesirable work. Members of the medical profession, on the other hand, have not experienced the same caste prejudice. Somjee writes:

Conversely, there was a rule of thumb indicating that, if you were in the nursing profession, you could not be of high enough caste. Such rigid stereotyping did not apply to doctors who did very nearly all the same things as nurses did in terms of handling the human body. But so far as doctors were concerned, they fitted well into the old Brahmanical mould of teaching and healing ... As physicians practising western medicine, the tactile requirement came back for them, but as physicians they were also considered socially high enough to have some kind of non-stick, non polluting armour around themselves. Such an armour of protection did not extend to nurses. (Somjee 1991: 38)

Other studies from the region have also reported upon differences in the public perception of female doctors and other categories of female health workers, including nurses. As described by Somjee, this perception largely ignores the physical contact between physicians and patients, but in the case of nurses, has given rise to greater social censure. Whereas female doctors working in South Asia are associated with the high social value attached to the practice of *medicine* and thus viewed as 'respectable', nurses are associated with undesirable 'task oriented' labour that in turn labels them as belonging to a low social class.

¹¹ Although the caste system is primarily associated with Hinduism, other religious communities in India such as Christian and Muslims also have a social hierarchy and observe some of the same beliefs around ritual purity/impurity.

In their study of nursing careers in Pakistan, for example, French and colleagues point out that nursing has not been seen as an acceptable occupation for women in Muslim societies due to the interaction of nurses with men outside the family and nursing's association with domestic work (French et al. 1994). Medicine, on the other hand, is a high status profession in Pakistan and its increased accessibility to women as a career choice has contributed to the undervaluing of all other health occupations including nursing (French et al. 1994). Their interviews with Pakistani nurses indicated that becoming a nurse generated tensions within the family in which family members frequently expressed concern that this would have a detrimental effect on the social status of the entire household (French et al. 1994). Another study in Pakistan undertaken by Mumtaz and colleagues examined the work of female primary health providers (Lady Health Workers, village based family planning workers, Lady Health Visitors and traditional birth attendants) and found that disrespect from male colleagues and gender based cultural constraints leading to high levels of social control were among the difficulties experienced by these health providers (Mumtaz et al. 2003). At the same time, they highlight how female doctors by virtue of their higher class status, received much greater respect than primary health providers and were able to “*sidestep many of the social restrictions faced by poorer female workers*” (Mumtaz et al. 2003: 265). For example, Mumtaz and colleagues found that women doctors were able to interact with unrelated men in carrying out their work, arguing that their class superiority gave them the social distance and protection that removed suspicion of inappropriate behaviour (Mumtaz et al. 2003).

The perception of nurses as being of 'questionable repute' has been frequently reported in studies of nurses in South Asia. In communities where strict social norms govern interaction between the sexes, women's close proximity to men through nursing work has resulted in accusations of 'immorality' and 'prostitution' (Hadley et al. 2007; George 2005). With reference to Keralite nurses, George writes that many of her interviewees felt that they were seen as 'morally suspect' by their community due to their close contact with male patients and doctors, as well as their greater freedom of movement to cities outside Kerala (George 2005). In a recent study of nurses in Bangladesh, Hadley and colleagues report that there is an association between nursing and sex work in the public mind, particularly as it entails night duty and close contact with men. As nursing is also seen as 'dirty work', these perceptions sully the reputation of single female nurses and put them at a disadvantage in the bridal market (Hadley et al. 2007). Hadley and colleagues therefore identify what they term as an 'occupational role conflict' between the British model of nursing adopted since 1947 and

Bangladeshi societal norms. They demonstrate how the stigmatized view of nursing by society is internalized by nurses and contributes to the avoidance of nursing work by Bangladeshi nurses, characterized by their very limited time in direct contact with patients. Nurses typically avoided activities that were perceived as undermining their social status by requiring patients' relatives to take over those tasks as 'nurse surrogates'. As seen in Pakistan and India, Hadley and colleagues found that doctors are “*not subject to the same suspicions and condemnation*” and argue that this is due to the higher status that doctors are accorded by the public as well as the gendered nature of care work that is given much lower social value (Hadley et al. 2007: 1175).

A small number of recent studies have re-examined public perceptions of nurses in light of new developments in Indian nursing, particularly the possibility of international migration (Percot 2005; Nair and Percot 2006; Khadria 2007). Through examining the career aspirations and migratory paths of migrant nurses, these studies argue that migration is transforming the image of nursing as a low status 'undesirable' occupation into that which can bring material benefits to nurses' spouses and families through increased earnings overseas. Migration is therefore seen as a key opportunity for the upward mobility of nurses (Somjee 1991; Percot 2005; Nair and Percot 2006). The main arguments of these studies are discussed in more detail in the section below. As this literature has focused mainly on investigating nurses' social capital as *women* within Indian society, in this research study I take these findings further to examine the potential impact of migration on the collective social identity of nurses as an occupational group.

Indian nurses in the context of international nurse migration

Indian nurses are increasingly being studied as active participants in international nurse migration (DiCiccio-Bloom 2004; George 2005; Thomas 2006; Khadria 2004, 2007; Alonso-Garbayo and Maben 2009; Hawkes et al. 2009). The findings, particularly from questionnaire studies, indicate that the willingness of Indian nurses to migrate is linked to perceptions of higher pay structures abroad, increased possibilities for professional development, joining family overseas and dissatisfaction with social attitudes towards nursing in India (Thomas 2006; Hawkes et al. 2009; Khadria 2004).

As Pam Sharpe writes, until the mid-1980's studies on migration promoted the image of the typical migrant as 'young, single and male', where women were viewed largely as

accompanying 'spouses' or as 'refugees' (Sharpe 2001). The international migration of (largely female) nurses is therefore an important example of a female migrant pathway that has provided an opportunity to examine the gender dimensions behind migratory processes, the career expectations of migrants, as well as the roles of men and women in migrant communities (Sharpe 2001; George 2005; Kingma 2006). In her research on transnational migration from Kerala to Connecticut, George examines what happens within families and the community when there has been a transformation in gender relations brought about through female nurse migration, particularly in instances where women become economically dominant as primary breadwinners (George 2005). Studies of migrant nurses have also included an in-depth look at their adjustment to a new work environment, highlighting issues such as institutional racism, exploitation by recruitment agencies, and unfair pay and career structures (DiCicco-Bloom 2005; George 2005).¹²

Some studies have linked the process of migration to a notable shift in the social status of nurses in India. Somjee argues, for example, that the historical stereotypes about nurses are now considered to be largely irrelevant, and attributes this to factors such as increased employment opportunities overseas for nurses and a higher earning potential. These factors have started to encourage the entry of women from higher castes thus making the profession increasingly 'respectable' (Somjee 1991). Similarly, through their in-depth examination of migratory processes among Keralite nurses to the Gulf, Nair and Percot argue that migration is elevating the social position of nurses in Keralite communities as they are increasingly seen as internationally mobile and the potential recipients of foreign salaries (Percot 2005; Nair and Percot 2006). Whereas nurses previously had a 'bad reputation' and found it difficult to find marriage partners, they are now increasingly in high demand as demonstrated by specific requests for nurses on matrimonial advertisements (Percot 2005). Nair and Percot also write that nurses' increased value on the matrimonial market in Kerala is largely due to their high export potential and that their husbands are able to get work permits in the lucrative labour market in the Gulf through their wives. Consequently, nursing is seen as a 'life strategy' that is able to provide young women with the opportunity to gain social and economic rewards (Nair and Percot 2006). Percot also highlights that in addition to providing female nurses with a better economic and social status, migration also reflects nurses' desire for more autonomy

¹² In a qualitative study on immigrant nurses from Kerala living and working in the United States, some nurses reported being passed over for promotion and attributed this to racism (DiCicco-Bloom 2004). Abuses by some private recruitment agencies include hidden charges through agency fees, false or misleading information on accommodation, working hours, leave, insurance etc. as well as non-payment or non-compliance with the terms of the contract have also been reported (Kingma 2006).

and an escape from traditional familial and social structures that they find restrictive (Percot 2005). Consequently, both George (2005) and Nair and Percot (2006) provide a fascinating insight into changing gender relations brought about through the migration process.

Most studies on migrant nurses from India tend to focus on Keralite nurses with far less attention to understanding migration trends among other groups of nurses in India. This is largely due to the association between Keralites and the image of the 'migrant nurse', particularly as Kerala has a longer history of nurse migration than other communities in India. Consequently, in this research I investigate attitudes towards migration among a sample of nurses that include nurses originally from Kerala, as well as those from Karnataka and Tamil Nadu. In addition, as most studies focus exclusively on those who have already migrated or intend to migrate, there is limited information about nurses who demonstrate little or no interest in seeking employment outside India. Therefore, this study is one of the few that embeds migration amongst other career decisions involving a sample of nurses working in India at the time of the research. In this respect, through examining the reasons behind the decision to migrate, or alternatively, the decision *not* to migrate, the research builds upon knowledge on the profiles of nurse migrants as well as the decision-making processes around broader career pathways in nursing. The topic of migration is also explored further so as to understand migration in the context of professional discourses around nursing, particularly the strategies promoted by nursing's leaders in India to secure greater professional status.

This study draws greatly upon theoretical literature of the 'professions' for inspiration and guidance particularly with regard to investigating the ways in which occupations seek to gain control over occupational knowledge and skills, define themselves as 'professional' and develop a sense of professional 'culture' in which professional values, skills and approaches are communicated among their members and to the broader public. Although much of the literature is geared towards Western industrialized societies, theories around the exercise and maintenance of power relationships underlying occupational control may have a universal reach and thus open up the possibility for their examination in non-Western settings. The relevance of some of the key theories within the sociology of the professions is therefore examined through this empirical study of the nursing profession in South Asia. In the following sections I outline some of the key conceptual approaches within this body of literature and highlight potential areas of empirical contribution.

The sociology of the professions

Historically, an important area of discussion in the study of professions has been around what constitutes a 'profession'. An early dominant approach to characterizing professions is what Johnson refers to as the 'trait' approach in which professions were defined through a fixed set of attributes (Johnson 1972). The works of Greenwood (1957) and Millerson (1964) are examples of this approach. Greenwood, for example, identified five traits that distinguish a profession from other occupations - namely a systematic body of theory, authority, restrictions on admission, a code of ethics and a professional culture (Greenwood 1957). Similarly, Millerson examined a number of studies of the professions so as to identify a list of 'essential' elements included in various definitions (Millerson 1964). Another approach to the professions was to view them as having a functional contribution to the maintenance of society. This 'functionalist approach' saw professions as being defined by elements that promoted key societal values and were altruistic in that they provided a collectivity-oriented 'service' rather than promoting self interest (Parsons 1954). Within these paradigms, nursing was viewed as a 'semi' or 'para profession' in that it was not considered to possess all the attributes that defined 'a profession'. Nursing thus occupied a subordinate position to medicine, which has already achieved 'professional' status, and thus had authority over other health related occupations (Carr-Saunders and Wilson 1933; Etzioni 1969; Katz 1969).

Both 'trait' and 'functionalist' approaches have been heavily critiqued largely due to their taking the perspectives of the professions at 'face value' (Johnson 1972) as well as the lack of attention paid to historical and institutional forces that lend professions power and status over time (Parry and Parry 1976; Johnson 1972; Macdonald 1995). Consequently, the focus of sociological enquiry moved away from defining the innate characteristics of professions to a study of the circumstances in which members of occupations seek to define themselves as 'professional' (Wilensky 1964; Freidson 1970; Larson 1977). This also included examining the ways in which occupational members engage in a collective strategy to achieve autonomy and gain market control of services through restricting entry to those with specialized training and thus secure 'occupational closure' (Larson 1977). Although the 'professionalization' approach is seen as more securely grounded in a historical process of active engagement with the lay public and with the state in gaining power and autonomy, it has also been criticized for being too introspective with limited attention to societal

influences, particularly those related to social class and gender that can facilitate (or hinder) pathways towards acquiring professional status (Johnson 1972; Witz 1992; Macdonald 1995). Nevertheless, as proposed by Larson (1977) examining professionalization strategies as part of a collective professional 'project' is helpful in understanding the collective actions of members of occupational groups towards achieving and maintaining professional status (Larson 1977; Macdonald 1995). Professionalization, according to Larson, is a process through which a 'professional project' aims to improve the economic and social status of its members (Larson 1977).¹³ Professional projects, therefore, can be understood as efforts towards achieving collective 'social mobility' (Larson 1977; Macdonald 1995). It is precisely this process of engagement with the system of social stratification to achieve greater social and economic rewards that is the focus of my investigation into the professional project of nursing in India.

In exploring the professional project of nursing in India, this study does not reopen old sociological debates of whether or not nursing can or cannot be classified as a 'profession' in India. Almost all the interview participants used the word 'profession' to describe nursing and consequently, it is an important emic concept. It is therefore not the purpose of this research to set out criteria for the appropriate use of this term. Rather, the study sets out to examine the ways in which nursing's members are engaged in collective strategies to acquire increased status and power. As the concept of collective social mobility is a key theoretical paradigm that will be explored within the context of the nursing profession in India, in the section below I outline the definition of social mobility in sociological literature and its examination in the Indian context.

Occupations, social stratification and mobility

The study of occupations in sociology has traditionally been concerned with occupations as indicators of 'social status' (Sorokin 1927; Glass 1954; Blau and Duncan 1967; Boudon 1970). As Mach and colleagues point out, since the majority of people earn a living on the basis of occupational activity, occupational divisions are relatively easy to assess in empirical studies (Mach et al. 1978). Occupations have also been strongly associated with other social attributes such as social background and education and thus the study of

¹³ Larson bases her discussion on social stratification on the theories advanced by Max Weber that examine social stratification in light of economic, social and political determinants.

occupations has been central to the examination of social stratification¹⁴ (Sorokin 1927; Blau and Duncan 1967; Boudon 1970). An important feature of the study of social stratification within industrialized societies is the ability of individuals to 'move' within the social hierarchy - a phenomenon commonly referred to as 'social mobility'. While the focus of studies on social mobility has been on the 'individual', the possibilities of social mobility as a group endeavour have been examined within sociological literature through an analysis of the process of 'professionalization' (Larson 1977; Macdonald 1995). As highlighted in the previous section, sociologists studying the professions have viewed professionalization as a process by which occupations promote their collective interests including those of social class and gender as part of controlling wider resources of power and achieving a high social status for the occupation and its members.¹⁵

Pitrim Sorokin's classic work on social mobility that examines the movement of individuals through 'social space' has formed the starting point of a number of subsequent investigations into the determinants of social position within societies and the mechanisms facilitating or impeding the prospects of 'mobility' (Mach et al. 1978; Blau and Duncan 1967; Ohnmacht et al. 2009). Sorokin (1927: 133) defines social mobility in a broad sense as: *"the transition of any individual or social object or value - anything that has been created or modified by human activity - from one social position to another."* Sorokin identifies two principal types of social mobility - vertical and horizontal:

By horizontal mobility or shifting, is meant the transition of an individual or social object from one social group to another situated on the same level ... By vertical social mobility is meant the relations involved in a transition of an individual (or a social object) from one social stratum to another. According to the direction of the transition there are two types of vertical social mobility: ascending and descending, or social climbing and social sinking. (Sorokin 1927:133)

A historical thread within sociological studies on social mobility has been the emphasis on 'vertical' social mobility (Glass 1954; Blau and Duncan 1967; Boudon 1970; Beteille 1992).

¹⁴ P. Sorokin defines social stratification as *"the differentiation of a given population into hierarchically superposed classes. It is manifested in the existence of upper and lower social layers. Its basis and very essence consist in an unequal distribution of rights and privileges, duties and responsibilities, social values and privations, social power and influences among the members of a society."* (Sorokin 1927; 11). Not all sociologists agree that social stratification is hierarchical. For example, writing on social stratification in India, Depankar Gupta argues that 'differences' rather than inequalities also characterize social systems so that social divisions can also be horizontally arranged, such as in the case of languages, religions or nationalities (Gupta 1992).

¹⁵ For example, in their respective works, Johnson and Witz discuss how occupations such as medicine and law have historically represented the interests of upper class men and thus are dominated by this group (Johnson 1972; Witz 1997).

Within the Indian context, the study of social mobility has looked mainly at the possibility of vertical movement within India's caste system (Beteille 1992; Srinivas 1992, 1997). Here, the entrenched nature of the caste system has historically rendered Indian society as 'immobile' in that individuals are born into a caste and remain in that caste throughout their lives (Beteille 1992). Caste mobility is therefore not an 'individual' phenomenon but occurs when an entire caste moves up (or down) the caste hierarchy as a result of changes in economic or political power (Srinivas 1997). In his work on social mobility in India, Indian sociologist M.N. Srinivas employs the term 'Sanskritization' to describe the process through which a *jati* (caste) or sections of a *jati* acquire increased political power or wealth and begin to incorporate the practices of higher castes into their rituals and traditions where, over time, the 'noble origins' of the caste could be claimed. Sanskritization is therefore a means through which members of lower castes in the Hindu caste system have historically moved up the caste hierarchy:

It is well known that occasionally a Shudra caste (labourers) after the acquisition of economic and political power, Sanskritized its customs and ways, and succeeded in laying claim to be Kshatriyas (warriors). The classic example of the Raj Gonds, originally a tribe, but who successfully claimed to be Kshatriyas after becoming rulers of a tract in Central India, shows up the varna¹⁶ classification. (Srinivas 1992: 30)

Srinivas uses the term 'Westernization' as a process seen mainly among the higher castes in which members of these castes adopt increasingly Western lifestyle patterns. Contemporary Indian society, Srinivas argues, is characterized by simultaneous processes of Sanskritization and Westernization:

In the context of modern India, mobility involves not only Sanskritization but also Westernization. In several parts of the country, the higher castes took the lead in Westernizing their life style, and while the higher castes were Westernizing, the so-called lower ones were Sanskritizing. This should not be interpreted to mean that the upper castes were throwing out their traditional culture or that the lower were not Westernizing. Both were occurring in each category, but since Western education had spread more widely among the upper castes and more of them were in white collar jobs, Westernization was more conspicuous among them. The improvement of communications, the activities of holy men, the popularity of pilgrimages, and the spread of education in rural areas all contributed to the increased popularity of Sanskritization. (Srinivas 1997: 17)

¹⁶ Varna originally means 'colour' and refers to the hierarchical divisions by caste in Vedic Society into the four orders of Brahmin (priests), Kshatriya (warriors), Vaishya (traders) and Shudra (labourers).

While caste identity remains an important form of social stratification in India, sociologists writing on the caste system agree that caste divisions within Indian society are gradually loosening and being replaced by a class structure (Beteille 1992; Searle-Chatterjee and Sharma 1994; Srinivas 1997). This is particularly the case in urban settings in which traditional restrictions on social interaction with members of lower castes are difficult to achieve and thus are largely disregarded. As Indian anthropologist André Beteille argues:

Those who move into the slums of a large city leave behind a part of their traditional identity, including their traditional concerns for purity and pollution. The pavement dwellers of Calcutta include persons from all castes and communities, though not in equal proportions; it would be unrealistic to believe that old distinctions can survive unchanged under these new conditions of life. (Beteille 1992: 39)

In large metropolises such as Bangalore and Mumbai, an individual's caste functions as one 'identifier' among others, such as sex, age, place of birth, educational status, and so on. Traditional occupational divisions that have historically characterized the division of labour in India are also rapidly disintegrating in urban contexts with the expansion of 'new jobs' in the IT sector that have developed outside traditional caste-occupation delineations. Although marriage is one domain that has traditionally been characterized by endogamous caste unions, there is some evidence that this too is beginning to change. For example, following her research on caste and arranged marriage in India, Richa Chauhan argues that the increasing importance of class (determined by income, education and occupation) is gradually replacing the historical emphasis on caste endogamy within marriage arrangements in India (Chauhan 2007). Through examining matrimonial advertisements in India over three decades, Chauhan observed how the criteria desired for finding a suitable marriage partner has changed dramatically over this period. Chauhan writes:

This study of matrimonial advertisements in India found that with modernization, as economic stratification in society has changed in terms of caste and class, so have these factors in the sphere of marriage. With an increase in the significance of class over caste as a determinant of an individual's status in society, we also see an acknowledgement of these considerations in the arena of marriage. (Chauhan 2007: 165)

It is within this context of changing social relations in contemporary Indian society that I locate my study of Indian nurses. Although as discussed above, the emphasis on social mobility has been on caste mobility in India, I examine the strategies towards collective social mobility by an occupational group and whether these draw upon some of the processes

described by Srinivas, Larson and others to make 'status' claims. In doing so, the study analyses the importance given to a collective strategy to promote an ideology of nursing and if so, whether this ideology becomes central to understandings of a shared professional identity among nurses. This approach builds upon Johnson's assertion that:

We are, in part, engaged here in an analysis of professionalism as an ideology. Elements of the ideology are most forcibly and clearly expressed by those occupational groups 'making claims for professional status' and engaged in an ideological struggle. (Johnson 1972: 57)

Looking at competing ideologies in health care can also shed light on interprofessional relationships and the ways in which nurses understand and negotiate their status vis-à-vis the powerful team on the professional playing field - i.e. medicine. The following sections therefore look specifically at theories on professional power and particularly how this is defined and realized in medical settings.

Professional dominance - power over knowledge and expertise

Over the past few decades, an influential theory around the professions as a particular organizational form has been that of 'professional dominance' (Hafferty and McKinlay 1993). This came into prominence through the writings of Eliot Freidson, and particularly his work on the profession of medicine in 1970, followed by later works reaffirming and, in the face of later critique, clarifying his original position (Freidson 1970, 1993, 2000). Freidson's work is particularly focused around the notion of the professional dominance of medicine in which he postulates that medicine is 'the' profession in the health sector, as physicians exert both a social and legal mandate to exercise authority over health affairs, as well as authority of knowledge over the discipline of medicine. For Freidson, other health occupations including nursing are subordinate to medicine precisely because they cannot compete with the authority of physicians over medical knowledge and expertise (Freidson 1970). The importance of knowledge to claims for professional authority has been raised by other sociologists writing on the professions (Hughes in Coser 1994; Katz 1969). For example, in his study of nursing in the United States during the late 1960s, Katz argues that the key issue regarding knowledge is not "who knows most" but "who is the rightful knower" and states that both nurses and physicians accept that physicians are the ultimate 'guardians' of knowledge about a patient's illness (Katz 1969: 59). Nursing knowledge was therefore viewed as firmly under the general

umbrella of medical knowledge, the holder of which was the physician (Katz 1969; Freidson 1970).

Although Freidson's writings on professional dominance have opened up the possibility of in-depth analysis of how monopolies in knowledge and expertise are built and maintained, professional dominance theory has been criticized for its acceptance of the 'absolute' power of physicians and for its lack of attention towards the changing environment in which health care is organized and delivered. As Donald Light points out, professional dominance theory does not account for the possibility of its reversal through 'professional decline' in which the power of the medical profession can be weakened (Light 1993). In his study of the medical profession in the United States, Light uses the concept of 'countervailing powers' to look at the interaction between actors with competing interests, where the dominance of one party may be offset by other parties to redress imbalances in power. As Light states, countervailing powers include "*a handful of major political, social and economic groups that contend with each other for legitimacy, prestige and power, as well as for markets and money*" (Light 1993: 653). This framework is more inclusionary than that proposed by Freidson in that it does not take medical dominance as a 'given' but allows for a more flexible view of the struggles for professional authority and control over patient care, in which the concept of 'power' may fluctuate according to wider contextual factors.

Hafferty and McKinlay (1993) argue that professional dominance theory can be seen as a product of a 'golden age' of medicine that characterizes the period following the Second World War to the early 1970s, in which medical care was predominantly provider driven and in which physicians enjoyed a monopoly over the provision of health care. From the mid-1970's onwards, studies of the medical profession leaned towards counteracting the view of medicine as a static and unchallenged power at the apex of medical care, towards that of a profession subject both to trends that could either increase professional dominance or alternatively, erode its dominance. Arguments supporting challenges towards professional dominance cite changes in national health policy and the emergence of 'managed care', as well as an increase in public consciousness in which user demands are eroding physicians' control over the delivery of medical services (Haug 1975; McKinlay 1985; Walby and Greenwall 1994). These arguments include the notion of the 'deprofessionalization' of physicians in which challenges to medical authority by consumer groups, changes in medical technology and the increased dependence on allied health care workers, has resulted in an erosion of public trust and the privileged societal position of physicians (Haug 1975). The

growing trend towards 'managed care' in industrialized societies, which includes state level scrutiny and control over health costs, review and audit of medical practice and the shifting of responsibilities in patient care to allied health workers is therefore viewed as reshaping the professional power of physicians over the practice of medicine (Hartley 2002; Walby and Greenwall 1994; Barnett et al. 1998).

Although acknowledging some erosion around the edges of physicians' power and influence in the medical sphere, Freidson did not meaningfully retract from his original theory of professional dominance. In his later writings, Freidson maintains that the autonomy of the medical profession remains intact, where even in situations of 'high stateness' (where State policies and machinery exert influence over health care) medicine still has important powers (Freidson 1993). Freidson puts forward that the key issue in professional power lies in the control over work by the professional workers themselves and that as physicians still retain authority over medical expertise they have maintained their dominant position vis-à-vis other health occupations. Freidson points towards an internal stratification within medicine in which physicians practice in various specialities, conduct research, manage health care and are instrumental in policy decisions, all the while being bona fide members of the medical profession. Consequently, he argues that bureaucratization and other managed care processes have led to an internal 'vertical' stratification within medicine rather than a lateral appropriation of medical authority by others (Freidson 1993; Hafferty and McKinlay 1993). Like Freidson, other writers have also emphasized that rather than passively accepting a loss of professional power, the medical profession has countered threats to its status with strategies to maintain its control over health decisions such as investing in physician owned medical companies, as well as resisting the accreditation of new categories of health workers (Barnett et al. 1998; Hartley 2002).

Much of the literature on the medical professions in recent years has focused mainly on the emergence and consolidation of 'managed care' particularly in Western urban settings and is frequently based on arguments relating to a physician surplus. Less attention has been paid to the realization of professional dominance in contexts experiencing chronic physician shortages. In these settings, particularly in low income countries experiencing high levels of health worker shortages, increasing emphasis has been placed on shifting essential medical tasks to other available categories of health personnel such as nurses, midwives and community health workers (WHO 2006). These trends therefore open up new avenues of

research around the professional status of medicine in relation to the revision of roles and expectations of both medical and auxiliary health personnel working in resource poor settings.

For the purposes of this study undertaken in a non-Western urban environment, investigating the exertion of occupational control over health provision can provide an insight into the organization of care within hospital environments and the professional roles attributed to various categories of health workers. As such, professional dominance and its implications for the division of labour between medicine and nursing is worthy of exploration within the study setting. Here, a branch of medical sociology has looked specifically at the ‘boundaries’ between doctors and nurses in hospital environments to investigate whether these boundaries are largely symbolic, functional and/or open to negotiation and what these findings add to our understanding of medical professions. It is to this literature that we turn below, where I will discuss its relevance to the research questions in this study.

Professional boundaries and ‘negotiated order’

A large body of literature has looked at the development of nursing in relation to medicine, examining issues such as the interaction between nurses and doctors and the negotiation of professional boundaries (Walby and Greenwall 1994; Davies 1995; Porter 1995; Pringle 1998; Wicks 1998; Allen 2001; Salhani and Coulter 2009). For example, Walby and Greenwall’s research on the work of doctors and nurses in acute wards in NHS hospitals in the United Kingdom examines patterns of conflict and collaboration between physicians and nurses and in doing so, analyses the ways in which professional autonomy and authority are enacted in hospital settings (Walby and Greenwall 1994).

One approach to the study of boundaries between nursing and medicine has been to examine occupational jurisdiction in the provision of patient care and the relationships between doctors and nurses within the context of ‘negotiated order’ (Strauss et al. 1963; Strauss 1978; Svensson 1996; Allen 1997). In their paper on organizational life based on a study of two psychiatric hospitals, Anselm Strauss and colleagues argue that ‘negotiated order’ is the basis of all social order (Strauss et al. 1963). ‘Negotiation’ was used to describe patterns of interaction between actors in this context (doctors, nurses and patients) as a way to ‘get things done’ (Strauss et al. 1963). Strauss later developed a more comprehensive account of negotiations within a wider context that included organizational settings as well as political contexts (1978). Two studies that have looked at the theory of negotiated order within

hospitals and applied this to the division of labour between doctors and nurses are Svensson's study of surgical and medical wards in Sweden (1996) and Allen's study of a medical and surgical ward in the UK (1997). Svensson's study relies on interview narratives that depict the importance of face to face interactions between doctors and nurses and the ability of nurses to cross the medical boundary by actively influencing doctors' treatment decisions. Allen's study takes Svensson's analysis further by drawing on both interviews and ethnographic data to examine how nurses accomplish occupational jurisdiction in relation to their every day work and discovered that much of 'boundary blurring' between medicine and nursing was 'non-negotiated' rather than a result of face to face interaction (Allen 1997).

In the context of this study, I examine the depiction of boundaries between nursing and medicine in the interview narratives for a number of reasons. Firstly, these accounts offer the possibility of exploring nurses' depictions of nursing work and the ways in which they frame their professional role in relation to patient care. Secondly, the delineation of spheres of work between medicine and nursing provides a starting point from which to investigate the working relationships between nurses and doctors 'in situ'. Thirdly, nurses' perspectives towards a symbolic boundary between medicine and nursing can be analysed as to whether there are common perceptions of a collective professional identity in nursing and how nurses' view their profession in relation to medicine. In addition, through both the narrative analysis and analysis of field notes around doctor-nurse interactions, I examine the factors that give rise to more or less autonomy and control over nursing work, including the conditions that permit nurses to cross over into medical territory. This will also allow for a more fine-tuned analysis of the professional dynamics of doctor-nurse relationships in the study setting.

Gaining insight into the symbolic and practical features of the relationship between nursing and medicine in the study context is an important step towards investigating the factors contributing to a sense of professional identity in nursing. However, as this provides only a partial view of nursing culture, I have also looked towards the broader nursing literature to investigate theories and concepts that underlie the development of a collective 'professional self' among nurses.

The sociology of nursing

Literature on the sociology of nursing has developed somewhat separately from that on the medical professions and is often found in books dedicated to nursing and in nursing

journals, where this appears to be a common pattern in a number of countries including India. This is not surprising given the dominance of medicine in discourses around health care and the efforts of nursing to develop its own theories and empirical research. Like the sociology of medicine, most theories on nursing culture and practice are from Western countries and are very much bound to the nursing traditions and historical 'milestones' in these contexts, such as reforms in nursing education and campaigns for state registration (Abel-Smith 1960; Dingwall et al. 1988; Rafferty 1996). The history and development of British nursing in particular has relevance to former colonies such as India, where the legacy of British nursing remains in the area of nursing education. More generally, the study of the history of nursing also provides an important insight into the professionalization of a female dominated occupation within wider patriarchal societies. For example, in her work on the politics of nursing knowledge, Anne Marie Rafferty discusses the campaign for nurse registration in Great Britain against a backdrop of resistance to higher education for women where essentialist assumptions around women's intellectual capacities entered the registration debate (Rafferty 1996). The art of 'caring' was considered by those who opposed a central nurse registry to be anathema to 'professionalism' where emphasis was placed upon 'character' rather than the possession of scientific knowledge. Rafferty thus reminds us that the struggle for professional status in nursing was inherently different and more challenging than the professionalization of medicine, as claims towards scientific authority by (male) physicians went unquestioned and are thus part of what Rafferty refers to as the 'gendered politics' of professionalization (Rafferty 1996: 43).

The emergence of nursing as a 'natural' vocation for women is thus something of a double-edged sword, one side of which has offered women the prospects of financial autonomy and independence and on the other side, has placed nursing in a subordinate position to medicine from which nurses over the decades have sought to liberate themselves. Unsurprisingly, nursing has been examined from a feminist perspective and held up as an important example of women's work that reflects the gendered division of labour in society (Ehrenreich and English 1973; Garmanikow 1978). Nursing's subordinate status in the health system has been viewed as a consequence (and compelling example) of a patriarchal system in which women's labour was brought out of the 'home' and into the public sphere (i.e. the hospital) where it could be controlled by men, in this case 'medical men'. Feminist scholarship has argued that the concept of 'professions' and the hierarchy of occupations is a reflection of the sex-based division of labour and gendered values attached to work, including

work traditionally carried out by women, such as midwifery and nursing (Ehrenreich and English 1973; Garmanikow 1978; Pringle 1998; Witz 1992; Porter 1995). The relationship between nurses, doctors and their patients has also been referred to as the 'institutional family' based on gendered divisions of labour that was promoted in the early days of the professionalization of nursing (Garmanikow 1978; Evans 2004). According to this ideology, doctors assumed the role of 'father', nurses as 'mother' and patients as 'children' (Garmanikow 1978).

Another important part of the 'gendered politics' of professionalization is terminology. Historically, the term 'professional' was typically reserved for traditionally male-dominated occupations such as medicine and law and where female-dominated occupations were given the status of 'para' or 'semi' professions. As Ann Witz argues in her aptly titled work *Professions and Patriarchy*, conceptualizations of 'professions', 'professionalizing' and 'professionals' are based upon patriarchal structures characterized by the exclusion and subordination of women and the advancement of male interests and power (Witz 1992). Witz also uses the term 'professional project' to describe the historical process by which occupations seek to obtain occupational closure and establish a monopoly over skills and competencies in the market for services. In her analysis, readers are directed towards examining gender as a fundamental component of professional projects that shaped both the form and outcome of strategies to achieve occupational closure through the unequal resources available to men and women to claim 'professional status' and achieve collective social mobility during the late 19th and early 20th centuries (Witz 1992). Consequently, as Witz argues, it is possible to distinguish between male and female professional projects and that both forms are grounded within a patriarchal as well as a capitalist system.

For Witz and others, it is the interaction between social class and gender that creates power and control over occupational activities (Witz 1992; Macdonald 1995). According to Witz, medicine is an example of a male professional project engaged in by class privileged male actors supported by a patriarchal system that has subsequently sought to maintain occupational closure through a downwards exercise of power over subordinate occupations such as nursing. Nursing is an example of a female professionalizing project that has adopted a 'dual closure' strategy to consolidate its position in the medical system (Witz 1992). Witz demonstrates how this 'dual closure' is characterized by processes through which nurses simultaneously resist control and subordination from the dominant professional group (i.e.

medicine) while restricting entry into nursing to the unqualified in order to achieve occupational closure (Witz 1992).

The relationship between social stratification and nursing's status in the health system is not only relevant to the study of the history of nursing, but also for understanding the profession's status in light of contemporary social relations. Here, gender is not the only consideration. Rather, as Carpenter (1993) and Rafferty (1996) point out, attention to gender along with race and class can facilitate the analysis of nursing's social position both in relation to medicine as well as to the wider occupational structure. For example, Carpenter uses a 'social divisions' approach in which he suggests that social divisions of gender, race and class in wider society are reflected in nurses' relationship to other health professionals, particularly doctors, as well as in nurses' relationships with patients. Carpenter also argues that wider social cleavages along the lines of race, class and gender are reproduced through internal divisions within nursing itself resulting in differing patterns of individual and collective mobility among male and female, white and non-white nurses.¹⁷ The position of nurses in the health system, Carpenter argues, is both technically determined through its relationship with medicine as well as socially determined by these divisions:

One of the key features of a 'social divisions' approach is the insistence that developments in nursing and its general position in the health-care system are not autonomous, but crucially affected by balances of power in the wider society, which become represented in the health system. This is not to suggest that every aspect of nursing development has been determined from outside, or that 'technical' forces play no part in positioning nurses within the health-care system. And even if external forces do largely shape the room for manoeuvre available at any point in time to occupationally based social movements, this still leaves many choices open about what strategies such movements could realistically pursue. (Carpenter 1993: 96)

Adopting a broader social framework against which to analyse the effects of caste, class and gender is helpful to the study of nurses in India. As discussed earlier, in previous studies of nurses in India, the impact of gender and caste has been analysed in terms of the ways in which this status affects nurses as *women* in Indian society. This research therefore takes these findings further to examine the strategies adopted by the professional movement of nursing to engage with wider social forces that are seen to 'threaten' the social identity of nurses as a collective occupational group. In addition, as Carpenter suggests, exploration and

¹⁷ For example, racism has been cited by a number of writers as being part of nursing management and relationships between nurses (Carpenter 1993; Salvage 1985; Di-Ciccio Bloom 2004).

analysis of the 'choices' considered by the professional movement of nursing provides the opportunity to examine the internal dynamics of the professional project and the strategies debated and advanced by the profession's leaders to further the collective interest of nurses.

Nursing: an identity in crisis?

New trends in educational reform and the emergence of new practices in nursing have opened up old debates around the professional identity of nurses. A key focal point in literature on the nursing workforce has concerned itself with a discussion of whether nursing is a 'profession' or a 'vocation' or seen by nurses as both (Cohen 1981; McKay 1998; Magnussen 1998; Bradley 2000). Nursing as a vocation emerged from the vision of the ideal 'lady' nurse promoted by Florence Nightingale and her contemporaries who were anxious to rid nursing of its low status and working class associations and for whom it was essential that nursing be viewed as a 'calling' rather than a source of employment (Garmanikow 1978). According to some commentators, this traditional view of nursing as a moral activity undermines nursing's ability to demonstrate a scientific and technical contribution to medicine and also may depict nurses as a more quiescent and 'controllable' workforce (Traynor 1999; Mackay 1998; Allen 2004). Consequently, efforts to professionalize nursing have emphasized the importance of clinical and research skills in developing the field of nursing research.

Some studies demonstrate how facets of the vocational perspective are still alive in the narratives of nurses, particularly when accounting for their decision to join nursing. For example, Lois Magnussen's examination of the life histories of a sample of nurses who entered the profession between 1910 and 1980 found similar themes across the narratives such as the need to find a job to support their families as well as the desire to be 'of service' (Magnussen 1998). In her study on nurses in the north of England, Lesley Mackay examined narratives around the depiction of nursing as a profession and vocation (Mackay 1998). Rather than a unified view of nursing, Mackay found that different views emerged. Whereas some nurses saw their work in terms of vocation, others were more concerned with questions related to pay and career opportunities, thus advancing the notion of nursing as a 'career' rather than a 'calling'. However, Mackay highlights that the division between the 'professional' and 'vocational' nurse was not clear-cut and argues that although only 18% of nurses interviewed displayed an overtly vocational attitude to nursing, the concept of vocation was evident in the attitudes of many nurses regarding nursing practice and in depicting the

character of a 'good nurse' (Mackay 1998). Mackay suggests that it may be helpful to look at concepts around 'occupational ideologies' where between any occupational group, there are likely to be different ideologies that reflect the range of interests and experiences of its members (Mackay 1998).

In nursing, like medicine, a gap has been identified between what is taught in nursing schools and the realities of ward life (Melia 1987; Mackay 1998; Philpin 1999). In her study of the impact of 'Project 2000' educational reforms on the occupational socialization of nurses in the United Kingdom, Philpin examines the effects of nursing educational reform on nursing culture through the eyes of newly qualified (Project 2000) trained nurses as well as 'traditionally trained nurses'.¹⁸ Philpin's findings indicate a tension between the new 'Project 2000' nurses and 'traditional' nurses in terms of approaches to patient care. Whereas 'Project 2000' nurses were keen to implement the holistic and individualized model of care advocated in their training curriculum, they found that ward care remained fragmented and broken into specific tasks to be performed by different nurses and auxiliary staff. Similarly, 'traditionals' were suspicious of the greater theoretical knowledge of 'Project 2000s' and highlighted their weak clinical and practical skills. Philpin's research illustrates the internal and often generational tensions within nursing that are brought about through educational reform and the concern that this may challenge the traditional values of nursing, thus resulting in inter-generational nursing 'identities'.

Nursing and the professionalization of care

Perhaps a more revealing line of enquiry around the professional identity of nurses within the study setting is not so much about 'top level' identifiers of 'vocation' or 'profession' but rather around whether there is collective identity as to what nursing work means and does, and to use these conceptions to investigate collective understandings of professional identity. Examples of this 'bottom up' approach, for example, are found in the works of Davies (1995) and Taylor (1997) that look at the ways in which nurses differentiate their roles from those of doctors and how value is attributed to nursing functions. A number of studies have argued that nurses' narratives frequently demonstrate how 'caring' is emphasized as a critical part of nursing practice and central to nurse identity (Walby and Greenwall 1994;

¹⁸ Project 2000 was launched by the UK Nursing and Midwifery Council to modernize nursing by teaching nursing students practical, analytical and research skills with the purpose of improving confidence and to prepare them for the changing environment of health care.

Millward 1995; Huynh et al. 2008). While the notion of 'care' was advanced in Nightingale's time as a 'duty' in nursing, 'care' has come to signify a holistic and therapeutic approach to patients that includes understanding the 'lived experience' of health and illness, as opposed to a disease-centred pathological approach (May and Flemming 1997; Traynor 1999). Within this conceptualization of 'care', 'emotional labour' has been identified as a key caring device (Smith 1992; James 1992; Bolton 2000; Huynh et al. 2008).

The concept of 'emotional labour', developed by Arlie Hochschild in her study of flight attendants, has been much discussed with relation to nursing work (Smith 1992; James 1992; Gray 2009). In her work *The Managed Heart: the commercialization of human feeling*, Hochschild uses the term 'emotional labour' to refer to "*the management of feeling to create a publicly observable facial and bodily display*" and that "*emotional labour is sold for a wage and therefore has exchange value*" (Hochschild 1983: 7). While Hochschild highlights how 'feeling rules' are experienced by men and women in everyday life, she also emphasizes the gendered nature of emotional labour, where managing emotion is a routine characteristic of women's paid work. As part of this work, Hochschild describes how the 'smile' and 'friendly' attitude of the predominantly female flight attendant is synonymous with her identity as a Delta Airlines employee, as well as with the image of the airline (Hochschild 1983). In nursing practice, emotional labour has come to refer to both the 'soft skills' required in empathic communication with patients and the strategies used to manage emotions reflexively as part of maintaining a professional demeanor during patient interactions (Smith 1992; Henderson 2001; Gray and Smith 2009; Huynh et al. 2008).

Studies in nursing have demonstrated the importance given to 'emotional labour' by nurses working in areas such as hospice, pediatric and oncology nursing (James 1992; Li 2004; Gray and Smith 2009). In their research study that examined nurses working in three areas of clinical practice (primary care, mental health and oncology) in a hospital in east London, Gray and Smith found that nurses regarded emotional labour as a vital component of the caring relationship between nurse and patient and an integral part of the culture of care in health services (Gray and Smith 2009). Similarly, in a study of emotional labour among nurses working in a gynaecology clinic, Bolton writes:

They (nurses) confirm continually the view that their emotional attachment to the job reflects their commitment to quality patient care and that if they were able to be emotionally uninvolved then they 'shouldn't be in the job'. (Bolton 2000: 583)

Challenges to the 'caring' role of nurses therefore strike at the very heart of the nursing mandate and to conceptions of professional identity. The shifting of responsibilities towards supervisory duties as a result of the increased bureaucratization of hospitals and the introduction of 'managed care' structures is presented as a challenge to nurses' ability to provide holistic care (Davies 1995; Traynor 1999; Allen 2004). Celia Davies in her work '*Gender and the professional predicament in nursing*' devotes a chapter to what she terms as 'the polo mint problem' in nursing practice in the UK, where qualified nurses are increasingly finding themselves in the role of supervising and managing others, including students, auxiliary health workers and housekeeping staff. Davies writes:

The real dilemma is that qualified nurses find themselves in the main supervising and managing others who do most of the care delivery. In this situation, the practice of nursing, for the trained nurse, 'drops through the vacuum in the middle' (Pembrey 1985:47). This is the Polo mint problem that gives the chapter its title. (Davies 1995: 91)

In addition, Davies argues that the routinization of nursing into tasks to be undertaken by different 'pairs of hands', has detracted from nurses' ability to provide holistic and individualized care to patients (Davies 1995). Although some technical tasks are still carried out by qualified nurses, other traditional nursing duties related to the care of patients are being handed over to staff with little or no qualifications, thus supporting the view of nursing work as largely basic and unskilled. Davies' study also illustrates the professional dilemma posed by professionalization strategies in which career trajectories that take nurses into nursing management simultaneously remove them from the practice of nursing and lead to feelings of professional frustration. Davies thus highlights the gendered professional predicament in nursing, in which career trajectories of nurses resemble male professional projects in terms of their 'fleeting encounters' with patients, as opposed to being able to provide the unbounded forms of care that nurses value, thereby provoking a crisis in identity.

The association between 'holistic care' and nursing is thus increasingly being portrayed in nursing literature as problematic. This is largely because the therapeutic relationship between nurses and patients based upon an ideal of sustained holistic care does not correspond with nursing in 'real life'. According to Dingwall and Allen (2001), the centrality of emotional labour and holistic care to nursing work was constituted as the foundation of nursing's jurisdictional claims and was used to set nursing apart from medicine (Dingwall and Allen 2001). However, as medicine is also evolving and becoming more

focused on therapeutic relationships with patients, the provision of holistic care is no longer the preserve of nurses alone. In addition, the difficulty of organizing sustained, individualized care within hospital environments is at the crux of the theory - practice gap in nursing and also contributes to dissatisfaction and low morale where nurses are unable to meet this ideal (Dingwall and Allen 2001; Maben et al. 2007). Consequently, this has promoted some members of the profession to ask the question as to whether it is time for nursing to reformulate its mandate (Allen 2004; Maben et al. 2007; Law and Aranda 2010).

At the start of the 21st century, there are signs that nursing is again seeking to carve out a professional jurisdiction in an evolving health care environment that has a greater array of complementary and potentially competing health professions. Although the implications of any proposed reformulation of the nursing mandate to the professional identity of nurses is beyond the scope of this paper, some of the arguments highlighted in British nursing literature were found to resonate in the Indian setting and are discussed further in this thesis.

Summary

Nursing is an example of a female professional project that has historically sought to define itself against the dominant professional paradigm of medicine. Nursing's traditional role as the 'physician's assistant' is one that contemporary nursing movements in Western countries such as the United Kingdom are keen to leave behind in favour of establishing nurses as separate but 'equal' providers of health care. At the same time, the literature suggests that important debates remain within nursing, particularly around the benefits and purpose of reforms to nursing education and concerns around the traditional nurse - patient relationship as nurses increasingly move 'away' from the bedside into management functions.

Studies from the South Asian region indicate that the convergence of gender, class/caste and work is of great relevance to understanding the social identity of female health workers, including nurses in those settings (French et al. 1994; Mumtaz et al. 2004; Hadley et al. 2007). This research takes these arguments further, to examine whether concerns around the social status of nurses have been incorporated in professionalization strategies advanced by nursing leaders in India. The study therefore looks at the ways in which the professionalization strategies of nurses engage with historical precedents that have acted upon nursing's relative power and status within India so as to transform these as part of efforts to promote a modern agential project in Indian nursing. The study also seeks to investigate the

profession's view of the future direction of Indian nurses and the dilemmas and possibilities therein.

Chapter 2

Methodology

In this chapter I discuss the theoretical perspectives underpinning the study design and data analysis as well as the methodological decisions taken during the course of the research project. As the research process led me to reflect upon my identity as a non-resident Indian (NRI) researcher doing fieldwork 'back home', I engage in a discussion of the politics of representation in social research and relate this to the experience of managing my own biography as 'insider/outsider'. I also highlight the methodological and ethical issues that arose during the natural history of the research project and the ways in which these were managed as part of the fieldwork experience. In the section on data collection and analysis, I outline the study methods and approach to sampling. This is followed by a discussion of data analysis, including the ways in which the research design and analytical process drew upon aspects of grounded theory and a constant comparative approach.

Theoretical perspectives

It is well recognized that qualitative research methods are best suited for studies that want to explore the texture and nuances of the social world in an in-depth manner (Black 1994; Hammersley and Atkinson 1995; Mason 2002). A qualitative research design was therefore considered to be the most appropriate research methodology for various reasons. Firstly, as I am predominantly interested in the ways in which nurses construct a professional identity in nursing, an inductive, qualitative approach was viewed as the most appropriate means through which to elicit data on meanings and experiences identified with membership in the nursing profession. This decision also stems from ontological assumptions that view the notion of 'identity' as a social construct developed from the actions, experiences and perceptions of individuals in society and their interpretations of the social world.

Secondly, unlike quantitative methods such as surveys, qualitative approaches typically allow the researcher to adapt and refine questions of interest according to the data generated and to probe more deeply into different lines of enquiry as they become relevant (Black 1994; Green and Thorogood 2004; Charmaz 2006). Adopting a flexible approach to gathering data was particularly appealing with respect to this research as there is very limited information available on nursing culture in India. My research questions therefore are geared

towards the 'what', the 'how' and the implications of professional identity(ies) to the profession of nursing in India rather than surveying how widespread these identities are. A survey design was discounted at an early stage in formulating the research as I did not feel that there was adequate information upon which to design relevant survey questions. To do so would rely on a priori assumptions about what a professional identity 'is' in this context and may also introduce the problem of forcing data to fit existing hypotheses (Glaser and Strauss 1967).

Thirdly, this study was not carried out with the aim to 'test' theories derived from other contexts in an Indian setting. The wholesale application of theories around the professions developed in Western countries, without attention to the specific socio-cultural context of India, presents risks to the credibility of the research findings through the uncritical adoption of an ethnocentric lens. Moreover, such an approach introduces the potential to bypass the possibility of developing culturally sensitive understandings of the professions in non-Western settings. Rather, this study seeks to develop empirically driven hypotheses relating to the professional consciousness of nurses in India and to assess the research findings in light of the broader literature on the sociology of the professions including studies of nurses in other contexts. Consequently, through this research I aim to shed light on whether and how conceptualizations of professional identity in the Indian setting are influenced by indigenous social institutions, thus contributing to knowledge regarding the conditions under which occupations seek to professionalize and the mechanisms utilized by an occupation's members to define themselves as 'professional'.

Despite the natural fit between the research questions posed in this study and a qualitative research design, awareness of the criticisms frequently levelled at poorly carried out qualitative studies are pertinent to ensuring a systematic and rigorous approach to data collection and analysis. The most common critique of qualitative research is that it lacks scientific rigour through its emphasis on the subjective experience of the research participants as well as that of the researcher. It is felt that qualitative research is less actionable than quantitative research findings because the audience is not quite sure on what basis to judge the strength of the analysis and whether two researchers would arrive at the same conclusions. In other words, sceptics of the scientific nature of qualitative research often cite validity and reliability as the major concerns (Murphy and Dingwall 2003). As Mason (2002) points out, some of the critique levelled at qualitative research may have much to do with the design and analysis of qualitative studies in which researchers do not systematically convey how and why

methodological decisions were made, the effect these decisions had on the data as well as how the process through which data analysis was performed and achieved. In ethnography, for example, field notes are often treated as sacred and intensely private documents and consequently are not made available to the research audience or to other researchers (Hammersley and Atkinson 1995). The sharing of field notes can be problematic as researchers typically generate a large volume of observations and analytical insights that make sharing of these documents difficult. In the research process of this study, although research notes were written initially in journals carried along to the research sites, notes of each site visit were reconstructed into a narrative memo that was then entered into a Microsoft Word file and stored with each set of transcribed interviews. In this format, sharing of data with other researchers becomes more feasible.

Another technique used to strengthen the validity of the study's findings was to constantly compare cases within the data set so as to refine emerging theory, as well as to seek out contradictory evidence. This process also included comparing my findings to other studies on Indian nurses, particularly the works of George (2005), Percot (2005) and Nair and Percot (2006) on nurses from Kerala. This was particularly helpful with regard to the topic of migration. For example, in comparing my data set to those of these studies, I was able to note similarities and differences and to follow up on these to investigate the perceived opportunity/costs of migration for different groups of nurses. Consequently, throughout this thesis, data from previous studies are brought in where relevant to demonstrate how the findings of this research converge or diverge from previous research. Although the significance of this convergence/divergence is outlined more fully in the discussion, critical reflection of the research findings through constant comparison assisted in refining emerging theory regarding the functional importance of migration, as well as providing a more transparent account as to the evidence supporting the study's conclusions.

Data collection

As this study is mainly concerned with the ways in which nurses constitute the world of Indian nursing in their narratives, in-depth interviews with nurses were core sources of data. From a process perspective, interviews are helpful in that they can 'open up' responses, where the researcher can follow possible new areas of inquiry and probe for additional detail and clarification (Green and Thorogood 2004). Through the interview narratives of nurses,

my purpose was to examine nurses' presentation of their working lives and to use these narratives to probe for conceptions of professional identity.

Silverman (1998) criticises the overuse of interviews in qualitative research without sufficient thought as to their advantages and limitations, arguing that researchers frequently treat interviews as a mechanism that can provide insight into what people think and do, and therefore favour this method uncritically above others such as observation. Other qualitative researchers also share Silverman's view that the interview has its limitations, and frequently cite the potential mismatch about what people say in an interview and what they actually do in going about their lives (Gilbert and Mulkay 1983; Green and Thorogood 2004). Rather than being a neutral, value free process of eliciting information from interviewees, the interview functions as a social encounter between the interviewer and interviewee and thus subject to social rules of interaction, including 'impression management' (Green and Thorogood 2004; Goffman 1959). For example, participants may present themselves as rational, competent and morally worthy in their accounts to the researcher (Green and Thorogood 2004). The ways in which the parents of sick children present themselves as competent in relating to health staff, for instance, is described in Geoffrey Baruch's work on *Moral tales: parents' stories of encounters with the health professions* (Baruch 1981). The purpose of interviewing in Baruch's study was not to learn what parents *did* to manage their child's illness. Rather, through analysing parents' accounts, Baruch examines the ways in which parents frequently seek to illustrate their competency in learning about and managing their child's illness, thus demonstrating their moral adequacy as parents. Rather than telling us how doctors and parents interacted, the interviews revealed sites of conflict and cooperation in parents' interpretation of medical encounters. Consequently, in spite of their limitations in providing an infallible account of what 'really happens' in the social world under study, accounts generated through interviews are important for what they may be able to tell us about those who produced them (Hammersley and Atkinson 1995). Like Baruch's study, the ways in which nurses present themselves in the interview, including their perceptions of doctor-nurse encounters, is of key analytical interest in this research.

In addition to formal interviews, other forms of data were collected as part of the study. For example, articles on Indian nurses in Indian newspapers were used as data on recent developments in nursing and to follow up current issues of interest to the study, such as developments in nursing education and trends in overseas migration. My attendance at nursing events was also particularly helpful in identifying some key topics that occupy the

collective nursing agenda in the state. For example, I was invited to a nursing conference at the beginning of my fieldwork. My extensive notes of the presentations, panel discussions and interactions with participants were used to identify emerging themes that I then compared with those in the accounts from the in-depth interviews. This was helpful in developing emerging hypotheses and to explore whether there was a consistency regarding certain themes or issues. I was also able to probe for some of these issues more specifically in the interviews, particularly with members of the nursing associations. My attendance at these events also served another important function, that of being able to interact with nurses on an informal basis and to make contact with potential research participants.

Some techniques of ethnography were also drawn upon such as 'shadowing' nurses on rounds and observing events, conversations and interactions during visits to the research sites, conferences and workshops and in one setting, the nurses' hostel. This enabled me to examine some aspects of nurse-patient and nurse-doctor interaction and to get a feel of nursing life outside a formal interview environment. Keeping a field journal provided the opportunity to record observations of site visits, interviews and other events throughout the fieldwork process.

Ethnography is often considered to be the 'gold standard' of qualitative research particularly through its emphasis on studying the world in its 'natural state' and the production of thick descriptions of the research context. At the same time, there is disagreement about whether 'naturalism' can truly claim to study the social world in its most natural state through avoiding 'artificial' research environments such as those of surveys or formal interviews (Hammersley and Atkinson 1995). As Hammersley and Atkinson point out, despite their differences, both positivism and naturalism share in common that they both appeal to the model of natural science and social phenomena as existing independently of the researcher (Hammersley and Atkinson 1995). Therefore, although observation remains a major approach of ethnography, the idea that a 'naturalistic' ethnographic account through observation techniques is unproblematic in representing social reality has been largely rejected (Hammersley and Atkinson 1995). Consequently, the analysis of social interaction between researcher and research participants is of key importance to all forms of social research. Along with my attempts to describe events 'as they happened' in as detailed a manner as possible, reflections on my interaction with participants were also included in field notes and formed an important part of recording the data collection process. As I discuss further in the sections below, 'reflexivity' was particularly important with regard to building

rapport with the participants in the interview context, managing and presenting myself as a participant-observer during site visits and perhaps most significantly, in representing the views of the participants in this study.

Qualitative research and the politics of representation

Qualitative research has been criticized for being either too political or ‘not political enough’ in its purpose (Hammersley and Atkinson 1995). In the first case, some research may be seen as supporting a political standpoint, for example, promoting social justice for women, gay men and women, ethnic or racial minorities, working classes, and other populations (Murphy and Dingwall 2003; Green and Thorogood 2004). In the latter case, some traditions such as ethnography may be criticised for having too little political impact, in that they are not conducted with the explicit purpose of bringing about change (Hammersley and Atkinson 1995). Essentially, all research (including quantitative studies) could be designed and used for political purposes. However, as Murphy and Dingwall point out, there is a considerable difference between accepting that research is value laden and arguing that the purpose of research is to support political ends, the latter of which has an implication both for the analysis as well as for overall research ethics (Murphy and Dingwall 2003).

The politics of representation, simplified here as the conundrum as to ‘who’ speaks for ‘whom’, is tied to the production of knowledge and power and is a topic that is frequently raised in feminist research (Spivak 1988; Carby 1997; Hew 2003). Gayatri Spivak, in her influential paper ‘*Can the subaltern speak?*’ critiques the ways in which those who attempt to speak for the marginalized and oppressed (i.e. the subaltern) reproduce a Westernized, patriarchal and elitist discourse that continues to constitute subaltern experience as ‘the other’ (Spivak 1988). Spivak refers to the ‘epistemic violence’ in which hegemonic power relationships are reproduced in representations of the subaltern subject, representations that are generated from a position of power and privilege and where the subject of the representation remains ‘mute’.¹⁹ For example, in her discussion of the Hindu tradition of ‘sati’ (widow immolation) and its opponents and supporters during the colonial period Spivak compares the British colonialist approach to putting an end to widow sacrifice (“*White men are saving brown women from brown men*”) with the Indian nationalist pro-sati argument of the time (“*the women actually wanted to die*”). Spivak writes:

¹⁹ Spivak refers to men and women among the illiterate peasantry, tribals and members of the lower strata of the urban proletariat as being at the ‘silenced centre’ of epistemic violence (Spivak 1988).

The two sentences actually go a long way to legitimize each other. One never encounters the testimony of the women's voice consciousness. (Spivak 1988: 93)

While Spivak acknowledges the efforts of subaltern studies to formulate a new narrative of Indian nationalist history that emphasizes the perspectives and action of the rural peasantry rather than focusing on the nationalist consciousness of an Indian elite, she challenges the notion that subaltern studies allow the previously ignored voice of the subaltern subject to be heard. In seeking to answer her question of whether the subaltern can speak, Spivak argues that post colonial theories continue to represent the perspectives of a national, academic elite and in doing so, attribute a false consciousness to a collective group that is, according to Spivak, heterogeneous. Similarly, although Spivak welcomes attention to the issues facing the 'subaltern woman' in contemporary feminist studies, Spivak argues that her voice is still assumed by those representing a foreign and/or native elite who continue to invoke a dominant ideology, interests and power in their representations of 'Third World' women. Spivak writes:

Can the subaltern speak? What must the elite do to watch out for the continuing construction of the subaltern ... Reporting on, or better still, participating in, antisexist work among women of colour or women in class oppression in the First World or the Third World is undeniably on the agenda. We should also welcome all the information retrieval in these silenced areas that is taking place in anthropology, political science, history and sociology. Yes the assumption and construction of a consciousness or subject sustains such work and will, in the long run, cohere with the work of imperialist subject-constitution, mingling epistemic violence with the advancement of learning and civilisation. And the subaltern woman will be as mute as ever. (Spivak 1988: 90)

I refer to Spivak's work not because I constitute nurses in this study as a subaltern group that are without agency. This research does not have a pre-determined 'emancipatory' purpose where I am seeking to speak 'for' Indian nurses or on behalf of the nursing profession. Indian nurses regularly speak for and represent themselves both in an individual capacity and through their nursing associations. Rather, Spivak's question is pertinent to the politics of representation in social research and the assumptions that the researcher brings to understanding, analysing and depicting the experiences of their research participants. In other words, Spivak raises the importance of self reflexivity in which the researcher is aware of his

or her biography and its effects upon social interaction in the research context and in the interpretation of events.

In examining my status as an Indian-born, foreign educated researcher doing research in India, I have sought to identify and analyse the possible effects of my identity with my research participants and in the issues underpinning the topics raised in this study, particularly around caste, class and gender. Although it may be viewed as inevitable that Western analytical frameworks find their way into the analysis of my findings as a result of my British educational background, as stated earlier in this chapter, I attempt to avoid viewing the social world through an ethnocentric lens by seeking to explore emic conceptions of professional identity that emerge through the accounts of nurses. Although I do acknowledge that nurses' voices are interpreted through my analysis and while my findings are discussed in light of the wider sociological literature, much of which has been developed in the West, I do not seek to present the findings of this study as an 'alternative' or an exotic 'other'. Rather, I seek to contribute to knowledge of the 'professions' by expanding understandings of nursing culture through an analysis of identity formation among nurses in the Indian context.

Although there is no conscious political angle to this research study, aspects of the study could be seen as political in that I am addressing issues of caste and class that are highly politicized in the Indian setting.²⁰ Again, in exploring the influence of caste and class upon professional identity in nursing, I am not seeking to situate myself within contemporary debates on caste politics in India. The issue of caste is highly complex and not the focus of this research. Consequently, I refer to caste only in relation to the participants in this study and the extent to which caste (and class) considerations were found to shape career choices and experiences in nursing.

Another political issue that emerges in this study is the international concern around the 'poaching' of nurses from resource poor to resource rich nations. While not explicitly taking a position on migration, I examine the incentives and disincentives around international migration for nurses living and working in Bangalore. In doing so, I hope to enrich discussions with regard to international migration and to explore more fully the benefits and disadvantages of migration for the nursing profession. More specifically, this study aims to undertake an in-depth examination of the importance of migration for nurses from the south of India.

²⁰ For example, whether or not to include caste in the 2010 Indian census has ignited fierce debate within India ("Government not for caste census" *The Hindu*, May 5th, 2010).

Finally, I do not wish that this research only envisage its purpose as contributing to 'knowledge' on the professions. From a policy perspective, the findings of this study may also have the potential to contribute to the design of recruitment and retention policies that reflect the career aspirations and professional concerns of Indian nurses. In this respect, it is hoped that the research findings do prove helpful in developing a better understanding of nurses as a work force and towards strengthening human resources policy in the Indian context.

Managing the 'insider/outsider': reflections on being an 'NRI'

The following extract is from a memo based on field notes taken from the first day of my attendance at a state level nursing conference. This extract illustrates some of the personal identity issues that I encountered particularly at the beginning of the fieldwork that are elaborated upon further in this section.

My first entry into the world of Indian nurses came during the beginning days of my fieldwork when I was invited to a state level nursing conference for nurses in Bangalore. Before the opening ceremony began, all participants were invited for coffee and breakfast in a large marquee situated in a courtyard outside the main conference hall. A colourful melee of older women dressed in bright saris, younger women in salwar kameez²¹ and a number of men in smart trousers and shirts were standing around chatting. I felt immediately pleased that I too had worn a salwar kameez as this would make me less conspicuous and I would be able to circulate and talk to other participants without attracting attention. However, as I stood awkwardly by myself deciding which group to talk to, I realized that despite my choice of dress, initial entry into the discussions would not be an easy task. I immediately noticed that the language of discussion of many of the groups was 'regional' - some groups were speaking in what I recognized as Kannada, others in Malayalam,²² others in Hindi and some in English. Given that my language skills are limited to English and a basic knowledge of Hindi, I decided to stay where I was and observe. It was this rather peculiar behaviour which 'gave me away'. I realized that I was the only person not talking to anyone and this became apparent to other groups standing around who began to look at me curiously. After receiving a smile from a nearby group of girls I tentatively walked towards them and said hello in English. After a few more introductory sentences and questions and answers my cover was fully blown. However, my first conversations with Sabera, a young MSc nursing student from Manipur in Northeast India and her friend Shanti, from Karnataka, undertaking an MSc in psychiatric nursing, began to reveal the intriguing tapestry of who chooses nursing and why. (extract from Memo 'Nursing Conference')

As demonstrated by this extract, rather naively, I had underestimated the effects of my own personal biography on building relationships with the intended participants in this study.

²¹ Long shirt (kameez) and trouser (salwar) outfit frequently worn in India.

²² The state language of Kerala.

Rather than slotting in seamlessly among the groups of participants, I realized that I was in fact, an ‘outsider’ and as such, became quite self-conscious of my identity as a ‘non-resident Indian’ (NRI). Although this feeling did dissipate as the study progressed, this initial experience of uncertainty as to how to present myself stimulated a process of self reflection of my dual identity and the kinds of assumptions that may be brought to this study.

The term ‘NRI’ or ‘non-resident Indian’ is frequently used in everyday parlance and generally refers to members of the Indian diaspora, particularly Indian citizens who have migrated to another country as well as persons of Indian origin who were born or live outside India. My own personal biography corresponds with this description, where I was born in India but left the country at the age of two years to live in Britain, where I was naturalized as a British citizen. My father’s work then took the family to Switzerland. I spent the latter part of my teenage years in Switzerland and, after travelling again to the UK and Canada for higher education, returned there to live and work. Over the years I have frequently returned to India to visit family in and around Bangalore and spent my last two years of high school in Kodaikanal, a hill station in the south of India. My dual status as Indian-British means that I embody two cultures. As most of my formative years took place in the United Kingdom, the influence of British culture on my speech, fashion sense and persona is unmistakable. In addition, as my family is Anglo-Indian,²³ English has always been spoken at home and like most Anglo-Indians, we observe Christian festivals and traditions.

This dual identity presents a simultaneous state of being as both ‘insider’ and ‘outsider’ in India. Although I look Indian and blend into the cosmopolitan scenery of Bangalore that consists of foreign expatriates and Indians from different parts of the country, my Anglo-Indian background establishes me as culturally different from other sections of Indian society. In addition, an ‘NRI’ is typically viewed by Indians as a person who is somewhere on a continuum of being Indian and being ‘foreign’. At no point in conducting this research did I feel that being seen as an ‘NRI’ provoked a hostile reaction amongst my interviewees. Rather, many nurses were curious about my background and asked me what life

²³ Anglo-Indians are people who have mixed European and Indian ancestry. An Anglo-Indian is defined in the Indian constitution as “a person whose father or any of whose other male progenitors in the male line is or was of European descent but who is domiciled within the territory of India and is or was born within such territory of parents habitually resident therein and not established there for temporary purposes only.” (Government of India, 2007). Access at: http://india.gov.in/govt/documents/english/coi_part_full.pdf

The Anglo-Indian community in India is recognized for its distinct Anglo-centric culture, religion, traditions and cuisine. English is the language spoken by the community. Following the Independence of India in 1947, large numbers of Anglo-Indians left for Britain as well as other Commonwealth countries such as Australia and Canada. Anglo-Indians in India today predominantly reside in urban areas, particularly Calcutta, Bangalore, Mumbai and Hyderabad.

was like in Europe. Some nurses mentioned family members and relatives who had also moved to the United Kingdom. One nurse immediately laughed when I started speaking saying that her grandchildren talked like me, as her daughter was based in the UK.

It may be that as a person of Indian origin, I am considered to be an 'insider' in the overall Indian context, while other factors, such as my economic class, social background and the fact that I am not a nurse, may establish me as an 'outsider' in another more 'local' context. For example, on a couple of occasions I was mistaken for a medical student or a doctor. During a visit to the nursing superintendent's office in one site, the nursing superintendent introduced me to a consultant with whom she had just emerged from a meeting. After she explained the purpose of my research, the consultant exclaimed "*Oh! So that's what you're doing here. I thought you were one of us.*" When I asked him what 'one of us' meant, he replied that he thought I was a medical student. In another site, one or two patients also tried to attract my attention by addressing me as 'doctor'. Although I wore Indian clothes to all site visits, these outfits were somewhat 'westernized' in that they were a fusion between Indian and European design and were bought from the popular retail outlet 'Fab India'. My choice of dress and accessories may have therefore established me as someone of a wealthier background, thus leading to the assumption that I was a doctor or medical student. As I discuss in this thesis, medical training is considerably more costly than nursing, where most of the nurses in my sample came from lower-middle class backgrounds.

With regard to my non-nursing background, I was less concerned about this aspect of my personal biography than those related to my cultural status. As my research focused on an exploration of professional identity in nursing rather than an evaluation or appraisal of nursing care, I did not feel that a nursing background was required in order to carry out such a study. Moreover, I felt that the fact that I was *not* a nurse may have had certain advantages. The first of these was that nurses may have felt more at ease during my periods of observation at the hospital sites than they would have done if they perceived themselves to be 'evaluated' either directly or indirectly by a visiting nurse researcher. Secondly, it is possible that nurses explain their experiences and feelings attached to their work for a non-nurse listener in ways that are different to those used to interact with individuals who are already members of the nursing profession and thus assumed to understand such experiences intrinsically or who may bring their own interpretations of nursing to the interview encounter. Explaining nursing to a 'non nurse' may also provide nurses with the opportunity to speak 'for' their profession and this

presented an interesting analytical dimension in the research, such as the telling of 'Nightingale Stories' (see Chapter 5).

The challenges of balancing multiple identities in doing fieldwork 'at home' are well captured in Cheng Sim Hew's ethnographic study of *Women Workers, Migration and Family in Sarawak* (2003). In her study, Hew reflects on the ethnic and class differences between herself and the migrant Malay women she wished to interview. In the following extract, Hew describes how this difference in status became less of a feature of the interview discussion as she began to share her own personal stories in the interview context, thus demonstrating some of the mechanisms researchers can use to put participants at ease and to minimize the effects of 'social distance' within the interview context.

Not only am I a middle-class, university educated West Malaysian Chinese, I am frequently a customer in the places where they work. This was particularly awkward at the stage of setting-up the interviews ... I remember that on one occasion when I was trying to fix an interview with a waitress in a restaurant, an acquaintance dressed in her dining finery stopped by to ask me what I was up to. Immediately, I was identified as belonging to the other side of the divide regardless of what I said or how I dressed. The waitress felt very uncomfortable and promptly turned me down after she left. Fortunately, this distance was frequently narrowed during the interviews when I reciprocated with stories from my personal life. (Hew 2003: 27)

Like Hew's experience, I found that being open about my own background helped transform a more formal interview environment into that of a 'conversation'. Nurses frequently asked me questions about myself, such as where I live, where I grew up and so on, and this sharing of information typically led to a more relaxed interview setting. The most difficult interviews were those that functioned as a 'question' and 'answer' session and were characterized by less personal interaction. The few interviews where this occurred were with participants who were not so fluent in English and with a few of the younger nurses who were quite shy.

In analysing my identity and status in relation to my research participants, I have also taken some analytical inspiration from M.S. Srinivas' experience of conducting research in India. Unlike Spivak, Srinivas does not invoke social distance as fundamentally characterizing the relationship between researcher and research subject so that this invariably produces a hegemonic relationship.²⁴ Rather, Srinivas argues that Indian researchers doing research of a different caste or group in India are studying someone who is both an 'Other' and also

²⁴ Srinivas does note however, that anthropological study is commonly viewed as the study of 'the Other'.

someone with whom he (or she!) shares a few cultural forms, beliefs and values (Srinivas 1997). Consequently, Srinivas argues that such a researcher doing research 'at home' in India is:

...studying a self-in-the-Other and not a total Other, for both are members of the same civilization, which is extraordinarily complex, layered and filled with conflicting tendencies. (Srinivas 1997: 22)

My 'NRI' identity and upbringing has provided me with a certain level of intrinsic understanding of Indian culture and life. The research experience was therefore not unfamiliar and 'exotic' where I was able to recognize various cultural considerations and attitudes of Indian social life depicted by the research participants due to my own experiences and Indian heritage.

Managing the field

Doing research 'in practice' meant that on occasion, I had to adapt my methodological decisions and reflect upon some methodological assumptions in designing this research. For example, although I had opted for individual, in-depth interviews with the study participants, some hospital nurses expressed their preference to be interviewed in pairs. This was particularly the case with younger nurses, where the pair consisted of class mates from nursing training who worked in the same hospital or nurses who were colleagues on the same ward. I was initially concerned that interviewing in pairs may mean that the participants would feel less inclined to reveal 'personal' information around their life and career choices. However, I found that as the respondents knew each other well, the interview became more of an informal interaction that resembled a small group conversation. Many of the interviewees already seemed familiar with the life history and career choices of their interview partner and frequently nodded, laughed, agreed with or clarified points made during the discussion.

As has been pointed out in relation to the use of focus group discussions in qualitative research, group interviews are particularly helpful in providing information on how knowledge is produced and understood, the production and acceptance of normative values, as well as how group members interact with one another and with the researcher (Green and Thorogood 2004; Kitzinger 1994, Bloor et al. 2001). Using a pre-existing group helps create a more 'naturalistic' setting and may reproduce some of the discussions that students have around nursing outside the research environment. In this respect, interviewing 'in pairs' began

to take on a more analytical dimension, particularly as I began to observe the importance of friendships and social networks within nurses' accounts. As will be discussed later in this thesis, Indian society has a strong communal tendency where individuals see themselves as part of a group denoted by kinship ties, community, schooling, language, national identity and so on. In this respect, rather than being strange or unusual that nurses often requested to be interviewed along with a 'friend', such requests have a normative value within the Indian context.

I also observed that it was not possible to minimize my presence at some of the key events I attended during the course of the research, particularly a workshop held at one of the nursing colleges I visited and a two day nursing conference. This is because such events are strongly ceremonial and where 'outsiders' are frequently received as honoured guests. For example, when I arrived at the nursing college I was informed that the students were waiting for me to begin the opening ceremony, which in Indian tradition typically begins with a *puja* (ceremony) and blessings. Upon my arrival, I was quickly ushered to a large hall where the students were assembled. At the entrance, two female nursing students welcomed me and put a garland around my neck, placed a red *bindi* ²⁵ on my forehead and sprinkled a few drops of holy water. I then walked down the central isle of the meeting hall while the students stood up and clapped and I took my place on the dais next to the Principal of the college and some members of faculty. I realized then that my initial plan to quietly sneak in at the back of the hall to listen would have been impossible and thoroughly inappropriate. After giving a speech to the students about my study and providing some information about myself and my background, I sat in the front row while the nursing students gave presentations on breast cancer.

The nursing conference also began with a *puja* where the invited guests at the event (the university registrar, former government ministers, and senior teaching faculty) were blessed and gave introductory remarks to open the meeting. Although I was not part of the opening ceremony, I was introduced to the meeting participants and was requested by the organizers to give a speech about my research. I was initially concerned that my visibility may mean that nurses at these events would be reluctant to approach me to talk. However, this did not turn out to be the case. Both the student nurses at the nursing college and participants at the conference were friendly and curious, asking me about myself and my research. These conversations gave me the opportunity to ask about nursing and thus, were a

²⁵ A *bindi* is a mark on the forehead and is considered auspicious.

helpful source of information. Consequently, being 'outed' as a researcher did not scupper the possibility of collecting naturally occurring data. Rather, being a visible part of these events enabled me to make contacts and interact with a wider group of nurses outside the hospital setting and was an important part of gaining acceptance among members of the nursing community.

Ethics considerations

Ethics approval for the study was received from the ethics committee of the London School of Hygiene and Tropical Medicine. Ethics review was also sought in the study setting but this proved to be difficult as I was unable to identify a central ethics review mechanism that covered both government and private hospital sites. After consultation with staff at a Bangalore based social science research institute regarding ethical clearance processes, I submitted information about the study (consent forms and a description of the study) to the management of each hospital for review and to invite any questions or concerns about the research.

Some studies suggest that exporting Westernized ethics procedures to non Western settings can be problematic. For example, during her field work in a small village in Kerala as part of her study on infertility, Catherine Riessman encountered some difficulties in requesting that participants sign consent forms. Riessman writes:

Because women in Kerala are educated and literate, many informants read along as we communicated the contents of the consent form. Most women signed it. A significant number, however, were reluctant to affix their names. They were suspicious, not about interviewing or taping, but about the form. Perhaps they thought it a government document. Liza communicated the women's concerns to me (translating), and gently suggested we proceed. Over the many months we worked together, I sense Liza minimized the importance of informed consent, even deleting specific provisions. She decided what was relevant in the particular interview context, disrupting western practices. (Riessman 2005: 478)

As Riessman points out, 'signing forms' in contexts such as India is frequently associated with government information collection and thus may make participants feel uncomfortable. I discussed the issue of signing forms with research colleagues in Bangalore who also felt that people were, in general, reluctant to 'sign anything'. Therefore, it was proposed that I obtain oral consent before proceeding with each interview.

In order to ensure that participants understood and agreed to participate in this research, I gave each nurse an information sheet to read and invited him or her to ask any questions. After explaining that participation was voluntary and confidential, I asked whether I could proceed with the interview and orally recorded permission from each participant. Participants were informed that they could end the interview at any time and that all recordings and transcripts were being given an interview number so as not to identify individuals by name. Consequently, all names mentioned in interview extracts that are included in this thesis have been changed and nurses participating in the study have been given a pseudonym for purposes of writing up the findings.

Creating a relaxed interview environment meant balancing the need for formal research procedures with building rapport and putting participants at ease. This was not always an easy task. I typically began interviews with an introductory chat with participants where I invited them to ask questions about myself or my research. At some point during this initial conversation, I would then ask if it would be okay to turn on the tape recorder. As highlighted earlier, although most interviews proceeded in a relaxed conversational manner, a few did take on a more ‘question and answer’ style format and thus characterized a more formal interview. This may have also been due to other factors relevant to the interview context. For example, as nurses were typically interviewed as they came off their shifts, some may have wanted to get the interview over quickly so as to return home to their families, while others may have felt shy in communicating in English. As nurses in the study speak a variety of Southern languages (Kannada, Telegu, Malayalam and Tamil) as well as Hindi and English, it would not have been feasible to interview nurses in their native languages. As English is the language of instruction in nursing in educational institutions it was reasonable to interview nurses in English, and most nurses spoke English well.

The local realities of the research setting also put this study into some conflict with standard ethics practices. For instance, as experienced by Riessman, in some cases it was difficult to conduct interviews in a ‘private’ setting. The interviews in the hospitals were all conducted on-site, where most took place in a small room (such as a counselling room) off the wards. However, a few interviews took place in busy ‘public’ settings, such as the emergency room of one hospital. Some of the casualty nurses, as well as a few in other areas who agreed to be interviewed while on their shifts, preferred the interview to take place where they could be easily located. For example, one nurse in the private teaching hospital requested that we talk in a communal room outside the nursing superintendent’s office. During our discussion,

nursing life carried on in the background with nurses entering and exiting the room, including those who took a few minutes to listen to portions of the interview.²⁶ While my interviewee did not appear to be fazed or uncomfortable in this environment, I felt quite self conscious about interviewing in front of an ‘audience’. In another setting, the government maternity hospital, one or two interviews were conducted in front of a few other nurses who occasionally contributed to the discussion by agreeing with a point made by the interviewee or by adding their own thoughts. In these instances, although nurses may have withheld certain information in such a public setting, most appeared comfortable to talk in front of others despite the risks to the confidentiality boundaries of the interview.

These ‘public’ rather than private interview encounters led me to rethink some of my own Westernized notions of ‘individualism’ and ‘privacy’ and the dimensions of these in non-Western settings. In countries such as India, privacy may operate in a very different fashion to that in Western countries where, for example, ‘private’ conversations may automatically include the participation of family or close members of the community. Although the questions asked in the topic guide were not of a deeply personal nature and related for the most part to questions around the working lives of nurses, personal stories inevitably entered the narratives. Given the culturally located notion of ‘privacy’, researchers working on particularly sensitive health topics may therefore have to go to extra lengths to ensure a private interview setting and carefully consider how this can be realistically and safely achieved.²⁷

Sampling

Apart from state registration statistics, employment data of nurses at central and state level is not comprehensive. In addition, limited information is available on human resources and staffing in the private sector. It is therefore possible that many nurses who are registered with the Karnataka Nursing Council (KNC) are not currently working or have emigrated. Therefore, in the absence of a secondary data set from which to draw a random sample of

²⁶ I refer here to discussions between nurses coming in and out of this area, giving instructions to orderlies, taking telephone calls and so on.

²⁷ Being interviewed ‘alone’ may also have ethical implications in that where interviewers are male and participants female, this may lead to suspicion by family and community members and thus threaten the safety of the interview participants. Such considerations are taken into consideration in research on sensitive health issues. For example, interviewers engaged as part of a multi-country study on domestic violence against women followed a number of steps to secure a private interview environment, including bringing along another questionnaire on a non-controversial topic that could be used if the privacy of the interview was compromised (WHO 2005).

nurses, a purposive convenience sampling approach was utilized. So as to include the accounts of hospital nurses working in diverse settings, six different medical facilities and two nursing colleges were included in the study. Interviews with some nurses and doctors were also undertaken as part of a theoretical sampling approach so as to follow up on some emerging lines of enquiry.

In-depth interviews were conducted with fifty-six nurses and four doctors. Fifty-one nurses were interviewed across six health facility sites that included both government run and privately run institutions. Two private nursing colleges were also visited in which I interacted with students and staff and where I conducted in-depth interviews with both Principals and one member of teaching staff. The research took place over nine months that included a preliminary site visit for two months in April-May 2007, six months of field work between January and June 2008 and a month long follow-up visit in December 2009.

Access to the research sites was initially facilitated through contacts that provided me with the name of either the medical director or nursing superintendent in a selection of hospitals in Bangalore. In India, personal contacts and networks are highly utilized in both personal and professional endeavours. As I found with regard to this study, 'being referred' through a personal contact was enormously helpful in being established as 'credible' and I was typically able to arrange a meeting with relevant gatekeepers at each hospital soon after the initial request. These personal contacts included a PhD research student, university and nursing college professors, as well as medical doctors and nurses working in Bangalore hospitals with whom I was put in touch through a network that expanded during the course of my research.

For example, during my preliminary visit to Bangalore in April-May 2007, I arranged to meet a university professor whose research interests include health workforce issues in India. Upon her recommendation, I contacted a PhD student whose work she was partly supervising and that examined the impact of the General Agreement on Trades in Services (GATS) in relation to nurse migration. My meeting and subsequent correspondence over a number of months with Krushna Pattanaik of the Institute of Social and Economic Change in Bangalore was very helpful in identifying potential key informants and was also a way to discuss ideas and potential research themes. I then followed up with the contacts suggested by Krushna by telephone and email and met nurses active in the nursing associations who agreed to participate in this study and who also facilitated my contacts with colleagues in hospitals and nursing educational institutions in Bangalore. At the same time, I visited individual

nursing colleges in order to meet faculty, to discuss my research and to request an interview. Through this 'snowballing technique' I was able to develop an initial set of interview respondents who then recommended me to contact other colleagues working in hospitals and in nursing education.

Once I had narrowed down a list of potential research sites to include both private and public health facilities, an initial email or telephone call was made to the hospital management at each site either by me or by one of my contacts. Upon obtaining a response, I arranged a visit in person to explain the study and its objectives. Permission to conduct the research was sought directly from the nursing superintendent and, in some cases, the medical director of the hospital.²⁸ In other sites, agreement to carry out the study was given by nursing superintendents alone.

Nurses were informed of the research by the nursing matron and invited to participate. A wide age range of participants was desired so as to capture the experiences of nurses of different ages, as well as any generational differences in perceptions of work and career. Both male and female nurses were invited to participate in the study. However, as most nurses in India are women, the majority of participants were female. Participants were recruited to the study after consultation with the hospital medical director and nursing superintendent to inform them of the study's aims and methods, to request permission to interview on-site and to ensure that recruitment procedures were appropriate and in line with hospital protocols.

The interviews had no fixed time limit and typically lasted between 45 minutes and one hour. A few interviews were shorter (around 30 minutes) particularly where nurses were on duty, while other interviews lasted well over one hour. Questions were open-ended and structured around a topic guide. Although recording dialogues provides access to verbatim quotes, recordings do not capture non-verbal communication and therefore do not reproduce the interview setting in its entirety. Consequently, in order to complement data from the interviews, notes were made on the interviews in my field journal. These included observations of the interview encounter, impressions of the interview, as well as emerging lines of enquiry.

For the nurses interviewed across the six sites, the interview discussion was followed up with a few 'questionnaire' style questions to collect some demographic information about the participants. I felt that this information was important to understand more about the participants in my study and was also helpful in observing any differences or similarities

²⁸ This was typically where the medical director was my first point of referral and where I was subsequently put in touch with the nursing superintendent for her permission to interview nursing staff.

across the accounts. In addition to age and sex, I was particularly interested in looking at the 'home state' of the nurses, as well as their religion and caste. I also asked each nurse for the nursing qualifications that they currently held (e.g. Diploma in General Nursing and Midwifery, BSc in Nursing, MSc, specialized diplomas and any other qualifications). The information from these questions has been grouped and summarized and is presented in Appendices. I also include a table with pseudonyms for the nurses that I interviewed with their background information. As I mention these nurses by 'name' throughout this thesis, the reader can refer back to the table for more information about these individual nurses.

I conducted the majority of interviews with participants across the research sites. Prior to interviewing in Site 2, I was informed by the nursing principal that some nurses may not be so fluent in English and therefore it was advisable to have someone who could assist me in translating. Krushna put me in touch with Smitha, a fellow PhD student at the Institute of Social Change in Bangalore, who agreed to assist me with interviews at one of the sites (a private teaching hospital). Smitha had experience in conducting qualitative interviews and was also a fluent Kannada and English speaker. A small number of interviews (four) were therefore conducted in both Kannada and English where participants switched back and forth between English and Kannada and where Smitha translated the relevant portions. The transcriptions of these interviews were also undertaken by Smitha. Her presence greatly helped build rapport with the small number of nurses who were more comfortable speaking in Kannada. In addition, our post-interview discussions provided an opportunity for me to clarify locally relevant issues of caste hierarchy and organization in Karnataka as well as discuss nuances of social behaviour and attitudes.

In addition to the interview data, I conducted approximately twenty hours of observation in total. This included shadowing nurses on their rounds and sitting near the nurses' station so that I could observe interactions between nurses, doctors and patients. I was also invited to observe a heart bypass surgery at one of the sites and was able to attend a recreational activity involving patients at another. At one of the research sites, I visited the nurses' hostel on two occasions and spent time watching television, drinking tea and chatting with nurses after they had finished their shift at the hospital. These visits gave me a glimpse into the closely intertwined personal and professional relationships of nurses, particularly for those who lived in the hostel and who mainly came from Kerala. As highlighted earlier in this chapter, in addition to these periods of observation, I attended a two day state level nursing conference, the Karnataka State awards ceremony for International Nurses' Day and a full day

workshop at one of the nursing colleges. Notes of observations at the hospital, hostel and conferences attended were entered into a field journal during these visits and then written up as memos. This data was used to complement the interview data through contextualizing some of the findings and to fine tune emerging hypotheses.

Limitations

This study is based upon data from a selected sample of hospitals in the public and private sector. These sites were selected as part of adopting a convenience sampling approach and were chosen as *examples* of public/private institutions. Consequently, I am aware that other medical institutions could have been included in the study, such as military hospitals, large corporate hospitals, nursing homes and other medical facilities. To include a larger range of research sites in this study would not have been feasible in terms of cost, time and the extent of data generated for analysis by one researcher. It was also not possible to undertake long periods of in-depth observation at each site within the time frame of fieldwork. Although this study is not an ethnography of hospital life in an Indian setting, such a study would provide a more detailed ‘in situ’ analysis of nursing practice in Indian hospitals.

Data analysis

The main approach to data analysis draws upon the ‘grounded theory’ method developed by American sociologists Barney Glaser and Anselm Strauss (Glaser and Strauss 1967). An appealing characteristic of grounded theory is its ‘funnel approach’, whereby the initial research questions and hypotheses are fairly broad and then progressively defined according to information emerging from the data. In the grounded theory tradition, data collection is predominantly guided by emerging theoretical categories in which researchers gather data to expand on or to eliminate preliminary analytical leads. I considered the ‘theory generation’ aspect of grounded theory to be more suitable in responding to my research aims over other approaches such as ‘framework analysis’, for example, which typically has the design of policy as its immediate goal (Ritchie and Spencer 1996). In the following section, I discuss grounded theory further and outline the ways in which I drew upon some of the techniques of grounded theory in analysing my data set.

The fundamental premise of grounded theory is that the analysis should be ‘grounded’ in data. The key activity in using a grounded theory approach is to develop theory through a cyclical process of gathering data, undertaking an analysis and checking out emerging theory through further data collection. This involves ‘theoretical’ sampling where the process of data collection is controlled by the emerging theory (Glaser and Strauss 1967). Throughout the process, categories are developed that become the building blocks of the emerging theory. The research is brought to a close at the point of ‘saturation’ whereby no additional data are being found for the research to further develop the properties of the category. In order for categories to develop and become saturated, the researcher compares cases and their properties to one another to account for similarities and differences and to follow up exceptions within the data set through analysis of ‘deviant cases’. The process of grounded theorizing can also involve comparing cases within the data set to data or theory in other substantive areas, particularly when developing formal theory. For example, as Kathy Charmaz suggests, in developing theory on the formation of identity following an unexpected event such as illness, a grounded theorist may compare the construction of identity among the chronically ill with those of people who experience loss or uncertainty in other circumstances, for example those who have recently lost their jobs and encounter economic insecurity (Charmaz 1990). In light of this comparative technique, grounded theory is also referred to as the ‘constant comparative method’. Glaser and Strauss argue that it is the continual revision and fine-tuning of the analysis through the constant comparison of data that provides the researcher with confidence in the analysis and development of theory (Glaser and Strauss 1967).

Grounded theory is seen as a systematic way to approach research design and analysis and, therefore, is often used in qualitative research (Green 1998; Charmaz 1999). As supporters of the grounded theory method argue, the main advantage of a ‘grounded’ perspective is that the categories that make up the developing theory are derived directly from the data set (Glaser and Strauss 1967; Corbin and Strauss 1990; Charmaz 2006). This avoids the potential for manipulating or forcing data to fit theories that may be imposed on the data set. Through continual analysis, comparison and theoretical sampling, theory can become rich, complex and dense rather than descriptive (Glaser and Strauss 1967).

One of the disadvantages of the grounded theory approach is that achieving saturation of categories can require a great amount of time. In the case of this research, it was not possible to undertake the theoretical sampling approach outlined by Glaser and Strauss (1967) where sampling is determined purely by the emerging theory, as this would involve an indefinite length of time collecting data. The time lag between data collection, analysis and further collection of data through theoretical sampling would have extended the time frame beyond what was feasible for this research. However, preliminary analysis of each interview and each 'round' of interviews at each research site did occur alongside data collection where I began to note themes and categories that emerged in early interviews and began to test and refine emerging hypotheses in subsequent interviews and in relation to other data collected, such as field journal observations and notes from the nursing events attended. For example, in exploring depictions of the doctor-nurse relationship, I held further interviews with doctors to discuss inter-professional working during a return visit to one of the field sites in December 2009.

Analytical process

Each interview recording was transcribed and read numerous times for familiarity. This was followed by line-by-line open coding, where these early codes were listed in a preliminary coding scheme along with properties and dimensions of the code. Research memos were then written to further analyse and link these codes together. As the analysis of transcripts progressed, codes were revised with properties added or deleted through constant comparison with cases across the data set. Cases were compared to one another according to site of work (public/private/clinical setting), as well as across age, religion and type of degree. Narratives of male nurses were also compared with those of female nurses.

Relevant parts of the interview transcripts (interview number and lines) were organized in a word document under a particular code. Through comparing codes and their properties to one another, I began to move from the codes to more theoretical categories. Here, the examination of deviant cases was critical to refining categories and to developing preliminary theory. For example, in coding for 'career advancement' I compared the testimonies of nurses interested in migration with those who were not. This enabled me to develop two core categories 'out of towners' and 'localites' to describe migration profiles of the respondents. The properties of these categories became the basis of an emerging theory

around migration as a career strategy. This enabled me to answer the question of ‘for whom is migration an attractive career possibility and why?’

Research memos were written to keep track of emerging codes, hypotheses and theoretical reflections. Memos written later on in the research process built on previous memos and were organized around theoretical categories and emerging theory. In writing these memos, I often went back to the original transcripts to re-examine my coding frame and to make necessary adjustments. Finally, through writing and rewriting memos and draft sections of the dissertation which, as Charmaz (1990) points out is a crucial phase of the analysis, categories began to unify around a central analytical theme, where the data was ‘put back together’ into a coherent whole. Corbin and Strauss refer to this as selective coding where categories unify around a ‘core’ category that represents the central phenomenon in this study and describes the main analytical idea presented in the research (Corbin and Strauss 1990).

Summary

This chapter has outlined the rationale and purpose of key methodological approaches to data collection and analysis taken during the course of this study. I have highlighted some of the challenges of positionality in social research, including reflections on my ‘dual identity’ status with regard to conducting research in India. As discussed in this chapter, I am aware that the interview functions as a social encounter and not as a transparent window into nursing life in the study setting. It is precisely with the description of nursing life that emerged in the first few interviews with nurses, that I began to explore constructions of professional identity among nurses in my study setting. I therefore invite the reader to examine the dimensions of this identity as laid out in the following chapters.

Chapter 3

A ‘suitable job’: becoming a nurse

In contemporary India, women’s participation in the labour market has increased dramatically including in the expanding sectors of banking, communications and information technology (Gothoskar 1995). In Bangalore, the possibilities of working in the mushrooming private sector - for example, in the large IT parks in the city, in foreign firms outsourcing their labour to India as well as in media, tourism and retail provide an increasing array of employment opportunities for young graduates looking to join the workforce. Given the different career options available to young men and women in large Indian cities like Bangalore and in light of the problematic historical associations between nursing and low status work, I was particularly interested in investigating who is choosing to enter nursing and why. This would enable me to answer the two key research questions that formed the starting point of my investigation into the nursing profession in India. These are firstly, which factors are influential upon the decision to enter nursing and secondly, do these factors indicate a shift in the ways in which nursing is viewed as an acceptable occupational choice? In addition, by asking questions related to a central theme of ‘why nursing?’ I would also be able to explore nurses’ feelings and attitudes towards their profession where this could shed light on the formation of professional identities.

The following chapter begins by describing the study participants and looks at demographic data, including the ‘home state’ of nurses, their religion and caste, as well as sex and age. This information then leads us into a discussion of the gender, caste and class related considerations that designate nursing as a ‘suitable job’ for some and a more problematic choice for others, followed by the economic and social incentives that are transforming nursing into a ‘job with prospects’. In this chapter, I also examine the emergence of ‘nurse families’ in which nurses act as role models to younger family members. In addition, I will discuss whether a changing image of nursing is attracting young women from more diverse backgrounds, as well as increasing numbers of young men into the profession.

The participants in this study

A common perception of Indian nurses is that they are predominantly from Kerala and that they are Christian. This has been reinforced by studies undertaken on Indian nurses that have looked specifically at the Keralite nursing community (Percot 2007; George 2005) as well as articles in the Indian media (*Deccan Herald*, May 26th 2009). As the history of nursing in India originated among the Christian community particularly in the South, this perception is well founded. In the late 19th and early 20th centuries, nursing recruits were increasingly drawn from the Anglo-Indian and Christian convert community, where from the late 1920s there was a marked increase in the inflow of nursing students from Kerala (Abraham 1996). As Meera Abraham writes in her historical account of missionaries and nursing history in South India: “*Kerala was and still is a prime area for the recruitment of nurses*” (Abraham 1996: 83).

Despite the relevance of this history and tradition to nursing in India, the presence and contribution of other non-Keralite and non-Christian nurses to the nursing profession has been somewhat masked. Therefore, I was very keen to sample a range of respondents during my visits to the hospitals so that I could understand and compare some of the pathways into nursing for other communities.

Of the fifty six nurses interviewed, sixteen were from Kerala, thirty four were from Karnataka, four were from Tamil Nadu, one was from Andhra Pradesh and one was originally from Bihar, but whose parents had settled in Karnataka. Consequently, the data set presented an overwhelming picture of nurses from the south of India (see Appendix 1). It is difficult to ascertain the numbers of nurses from the north of India working in Karnataka as comprehensive employment data from the private sector is limited, but the fact that the sample consisted entirely of nurses from the southern states was not unexpected. Apart from the history of nursing in the south of the country, the difference in language and culture between the south and the north of India would present a formidable barrier for Hindi and other northern language speakers. While many ‘southerners’ speak or understand at least two or more southern languages, and can communicate in the national language of Hindi as well, ‘northerners’, whose language is based on an entirely different script, typically have little or no knowledge of southern Indian languages. Therefore, the few nursing recruits that I met from northern states of India were almost exclusively nursing students who had come to one of the many nursing schools and colleges in Karnataka to study. The one nurse originally

from Bihar, who was also my only Muslim respondent, was born and brought up in Bangalore and consequently spoke Kannada fluently.

In terms of the distribution of respondents by 'home state' at each of the sites, all the Keralite nurses interviewed were in the private hospitals. In both the public hospitals, none of the nurses interviewed were from Kerala, where the sample obtained consisted overwhelmingly of 'local' Kannadiga²⁹ nurses and a handful of nurses from Tamil Nadu. I was unable to ascertain how many Keralite nurses are working in government hospitals in Karnataka. Although some nurses in the government hospitals told me that they worked alongside a few nurses from Kerala, it appears that comparatively few Keralites work in government facilities in Karnataka, as employment is mainly reserved for 'local' state nurses or those from other Indian states who have settled permanently in Karnataka and thus satisfy the residency requirements for working as a state government employee.

Religion and caste

Out of the fifty-six nurses, twenty-six were Christians, twenty-nine were Hindus and one was a Muslim (see Appendix 2). Given the 'Christian' influence on nursing in India, I initially expected that my sample would be largely skewed towards the Christian community. However, Hindus accounted for slightly more than the number of Christian nurses. Although the study size is too small to provide a representative picture of the religious background of nurses in India, both my results and those from other small scale studies, such as Geeta Somjee's study in Gujarat, indicate that nursing is increasingly being taken up by Hindus (Somjee 1991). The almost negligible presence of Muslims indicates that nursing was and still is not a popular choice among the Muslim community. When I asked nurses whether they worked alongside Muslim nurses, their response was that this was 'rare', and that only a few of their colleagues were Muslims.

In terms of the Hindu caste breakdown, the nurses in my sample were predominantly from the lower castes in the Hindu caste hierarchy. Out of the twenty-nine Hindu nurses interviewed, six were from what the Indian Government classifies as 'Scheduled Castes' (SC), two were from the 'Scheduled Tribes' (ST), and eleven were from the category 'Other Backward Castes' (OBCs).³⁰ A further two were from the Naidu community, formerly

²⁹ Kannada-speaking.

³⁰ The terms 'Scheduled Castes', 'Scheduled Tribes' and 'Other Backward Castes' are classifications used by the Central Government of India to categorize citizens based on their social and economic condition.

classified as OBC, found in different states in the South. Five nurses however were from 'high' or 'forward Hindu castes', particularly Nairs (Kerala) and Lingayats (Karnataka) and one nurse from the Nagarathar caste (Tamil Nadu). Specific caste data was not obtained from three of the Hindu nurses, although one indicated that she was from a high caste family. Of the eleven from the OBCs, ten were from the Vokkaliga caste, where most identified themselves as being from the 'Gowda' sub-caste and one from the Panicker caste. Vokkaligas are the largest community in Karnataka and are mainly agricultural, where Vokkaliga means 'one who tills the land'.

An important note with regard to caste is that the list of castes identified as OBC, ST and SC is flexible and often updated with castes added or removed according to social, economic and educational indicators. They may also be classified as OBC or SC in one state and not in another. In addition, caste is a highly politicized phenomenon, where different castes, including OBCs, STs and SCs have a strong power base in some states. For example, the Vokkaliga community wields great political power in Karnataka, many of whose members have occupied key positions in the Karnataka state government, and in the case of one former Karnataka Chief Minister, H.D. Devegowda, the post of Prime Minister of India. In recent years, two large caste communities, the Vokkaliga Gowdas and Lingayats, have dominated the political scene in Karnataka. However, despite some political gains for lower castes, a recent report from Karnataka shows that there is a wide gap between the Scheduled Castes and the general population in almost all human development indicators, where a similar trend is found throughout India (Government of Karnataka 2006).

Although caste does have an important place in the study of Indian occupations, there is evidence of a loosening of the caste-occupation relationship (Government of Karnataka 2006). Historically, caste was intimately connected to the occupational hierarchy, with higher castes having better access to higher status and higher income occupations and assets than lower castes (Government of Karnataka 2006). However, in the modern day context, particularly in Indian cities where 'new jobs' that are free from traditional caste boundaries are increasing, such as in the IT and service sector, there are growing opportunities for communities to transcend traditional caste norms in the choice of occupation. For example, a look at some of the ubiquitous Indian matrimonial sites shows that jobs in fields such as engineering, medicine, information technology, banking and finance are being taken up by men and women across religion and caste. However, one important note here is that these sites have a more urban and educated bias, where in the rural areas of India in particular, caste

divisions remain considerably more entrenched with regard to literacy and education. The Government of India and each State Government therefore set reservation targets in the education and job sectors for SCs, STs, OBCs and other disadvantaged groups so as to elevate the status of these communities and facilitate their entry into a wider range of professions. Consequently, the majority of Hindu nurses that I interviewed from SC communities had obtained a 'government seat' in nursing colleges, where their nursing fees and expenses were covered by the state.

Sex and age

The nurses interviewed were overwhelmingly female (49 nurses). Seven male nurses participated in this study, where five worked in private health facilities, one worked in the central government managed hospital, and one was a nursing principal (see Appendix 3). The much larger concentration of women in my sample is indicative of the larger overall numbers of women in nursing in India. Some hospitals in India exclusively hire female nurses, as is the case with one Christian mission hospital included in my sample. However, in India, as in other countries, men are increasingly being trained as nurses (Choy 2003). For example, at the two nursing colleges I visited there were a number of male students, where in one college, male students accounted for almost 50% of the student body. As both Principals of the nursing colleges told me and as was reaffirmed by my data, the rise in the numbers of male students indicates the increasing popularity of nursing as a choice for boys where this is largely due to the prospects of employment both in India and overseas.

In terms of the age range of nurses included in my research, the youngest nurse was 22 years old and the oldest was 80 years old and retired. The nurses interviewed at both government hospitals were generally older than those interviewed in the private sector. At the first government site, the nurses ranged from 30 to 59 years and the second, from 32 years to 57 years, whereas in the first two private hospitals visited, most nurses were in their twenties. Discussions with hospital management in the private settings indicated a high turnover particularly among younger nurses who, after completing two years of nursing experience, frequently left for postings abroad. In the government sector, the nurses generally had more years of experience and had stayed in their jobs for a number of years.

‘Getting a job’: intersections between gender, class and nursing

The reproduction of normative assumptions of ‘male’ and ‘female’ values and behaviour within human societies is particularly evidenced by the gendered division of labour and as such, has been discussed in great detail in feminist literature (Garmanikow 1978; Bryson 1999; Mies 1986). The codification of ‘essentially female’ attributes such as caring and nurturing and the extension of women’s traditional domestic roles underlie occupations associated with women, including nursing. As in other countries, the popular image of the ‘female nurse’ is also prevalent in India and reflects both the cultural associations between women and care-work as well as the European origins of modern nursing in India where women were recruited almost exclusively to the profession.

To this day, nursing continues to be a female majority profession in India. A number of nurses interviewed told me that they considered few other options and went directly into nursing after school. As Tara, a 28 year old nurse from Karnataka explained *“Everybody was going into this profession only. All girls, usually they will go to this one only. And even my mother, she told ‘you go to this’.”* Deepa, a 30 year old nurse from Tamil Nadu recalled how she did not know anything about nursing when she joined but as her sister was already a nurse, it was an available and feasible option.

SJ: Why did you decide to become a nurse?

Deepa: Firstly, I didn’t know anything about nursing when I joined newly. My sister was doing nursing. As soon as I finished my PUC (two year pre-university course), they said ‘Okay, sister is there no? You go and join.’ So, without knowing I went and joined.

Some of the male nurses interviewed also told me that in their communities, nursing was an automatic choice for their female peers. For example, Santosh, a male nurse I interviewed in a private hospital, pointed out with specific reference to his home state of Kerala, that choosing nursing for women was *“like a protocol”* where *“they won’t think much about other fields and all”*.

Female nurses who talked about other potential avenues of employment most often mentioned another female dominated service profession - that of teaching. It may be that teaching and nursing are two available ‘candidate’ jobs in that they involve work that is considered to be both gender appropriate, and where training is affordable, thereby being class appropriate. For older nurses, teaching and nursing were presented as among the few occupations available to them at the time. For example, Sophie, a retired 80 year old nurse,

told me that her choices were limited to 'teaching', 'becoming a nun' and 'becoming a nurse'. These may reflect the range of opportunities for women available at the time she was doing her schooling (the 1940s) as well as her circumstances (Sophie was orphaned and raised in a convent).

Cultural attitudes supporting the sex stereotyping of jobs meant that those who had other plans were pressured by family members to become nurses. For example, Prabha, a 25 year old nurse working in a private hospital, told me that she had initially wanted to become a lawyer. As her mother did not feel that law was a suitable choice for a girl, Prabha decided to drop these plans and entered nursing after listening to the advice of a neighbour. Prabha recalled:

Well basically I was not interested in nursing. I was interested to do law. I told my mum I will get into law. I am very much interested in law and she told 'No, it would be suitable for boys rather than girls. I don't want you to get into law'. That's what she said. So she was not very much happy that I get into law or something. So then I was thinking 'Which other profession will I go.' Then one neighbour, she had completed her nursing. She told 'it will be a good profession, you will have a good future. So, I said 'Okay fine, I'll join.' So it was just like that. I did not have options, I don't know, I did not have any other options, so I just went for that.

For some of the nurses interviewed, the view of nursing as a gender appropriate livelihood was also related to being able to acquire skills that are 'useful' within the household and not just within the walls of the hospital. Sarita, a 37 year old nurse working in the central government hospital, recalled being a reluctant recruit to nursing where she wanted to join a computer science course after finishing school. Sarita was resistant to the idea of nursing as her mother was a nurse and she was put off by the long hours and night shifts that her mother regularly worked. Like Prabha, Sarita recalls how her mother insisted that she join nursing for the skills it would provide her in looking after a family even if she decided to discontinue working:

Basically I wasn't interested in nursing. I wanted to do something in er, computer science was a very fresh thing at that time. I had got an opportunity in a government seat, but my Mum's a nurse so she was the one who forced me into nursing. She said 'No, you do nursing.' Her basic idea was that every woman should know how to give basic nursing care. Every woman should at least know how to care for herself and her family, so that wherever she is, she should know how to care. So, even if you don't want to do it in the future, you can leave and get married and get settled. But er, Mummy was a nurse and she could hardly find time for us. You know, the schedules are so different.

In India, as in many other countries, the care of sick and elderly family members has traditionally been the role of women and girls. As feminist scholars have long argued, the extension of gender based roles within households to the public work sphere has resulted in the funnelling of women into ‘feminized jobs’ and the subsequent ‘sex typing’ of occupations (Cockburn 1988; Witz 1992; Davies 1995). Although the female-centric history and development of nursing largely explains the overwhelming presence of women in the field, it does not fully account for why women would chose nursing over other options, especially in an urban setting such as Bangalore where a number of other avenues of employment are available to women. I was also keen to understand the motivation behind men’s entry into nursing. Interestingly, given the cultural perception of nursing as a ‘female occupation’, the male nurses interviewed as part of this study did not appear to have experienced any negative repercussions within their families or communities for joining nursing, as has been reported in other contexts (Littlewood 1991). Rather, the interviews strongly suggested that the perceived economic and social opportunities that can be accessed through nursing served as influential triggers for entry into nursing training for both men and women. Therefore, while gender acts as a historical ‘push’ factor underlying women’s entry into nursing, the decision to join nursing in particular among other ‘candidate jobs’ was found to be largely determined by the perceived advantages associated with entry into the profession.

Class or caste?

Socio-economic group and caste have been found to be positively related in India (Dalmia 2004; Iverson et al. 2010). As the majority of Hindus in my sample were drawn from lower and middle castes, this may indicate a relationship between caste, economic status and entry into nursing. Embarking upon nursing training is a costly endeavour. The average fees for a nursing student are between 70,000 Rs (approx 1,500 USD) and 1 lakh of rupees (approx 2,100 USD) per year for a Diploma (three years) course and a BSc course (four years) respectively, where the latter is considerably more expensive. Therefore, unless a ‘government seat’ is obtained, this excludes the poorest segments of Indian society, many of whom are drawn from historically marginalized castes, but also high caste yet economically poor families and low income candidates from Muslim and Christian backgrounds. Consequently, while caste trends provide a general guide to occupational segregation, caste by itself is insufficient to account for occupational choices such as nursing. The majority of

nurses in this study, regardless of caste or religious background, accounted for their decision to join nursing as being primarily ‘economic’ and thus class based.³¹ This does not mean, however, that issues of caste are no longer relevant to the study of nursing, as being of ‘high caste’ was highlighted by some nurses as a reason why nursing was *not* considered to be a ‘suitable job’. For this group in particular, the normative association between nursing and low caste work was particularly problematic and thus, their choice was considered by their families to be a deviant one regardless of the family’s economic status. For example, Savitri, a 57 year old nurse from Andhra Pradesh stated:

The impression, especially in Andhra Pradesh, nursing is just not even 1% of the girls that will go for nursing in my state. That too, from the upper caste, I mean in the Hindu community, hardly 0.1% you will not find.

Consequently, it was not “*in her father’s dreams*” that she would become a nurse. She also added:

Nurse means, I think, you know, there is some kind of barrier and that the upper caste boy in coming forward to get married, these are all cultural kind of drawbacks we had in our community.

Economic constraints within households emerged as being particularly important when discussing which occupational choices were readily available. For example, for most of the participants in the study, medicine would be out of reach from a financial perspective unless tuition fees and living stipends were paid through obtaining a free, ‘government seat’. The cost of tuition in medical colleges is expensive at around 1.22 lakhs (approx £1, 700) per year for candidates domiciled in Karnataka and 2.07 lakhs (approx £3, 000) for those from outside Karnataka (Frontline, 2003). Consequently, Soraya, a 22 year old nurse working in a private hospital told me, “*Medicine was not that affordable, so we thought fine, whatever our level, let us go with those things*”. Similarly, Lakshmi, a 52 year old nurse whom I interviewed in a central government hospital told me that as she was from a ‘poor family’, nursing provided an affordable option for her and her sisters, who were also nurses. As she explains:

³¹ I use ‘class’ here to refer to a shared social and economic background, rather than the Marxist definition of ‘class’ that is concerned mainly with the capitalist mode of production.

My elder sister did nursing. We are from a poor family, main thing is poor family. She did nursing. Then we followed her. But after seeing my sister's job, I liked it. I was telling, I went to her 'I want to do nursing'. Then she helped me and I became a nurse.

Although a few respondents specifically mentioned coming from a 'poor family', the majority appear to be from lower middle-class homes. In cases where I asked about father's or mother's employment, answers included farmers, shopkeepers, nurses and clerical posts in private and government institutions. Few, if any, of the nurses interviewed came from high income families where parents were in high education or high income professions such as medicine, law or finance. Therefore, there appeared to be, as one doctor put it, a 'selection bias' in nursing where those from upper middle class or upper income families would choose medicine over nursing, and that nursing is a more popular choice for those from lower middle income families.

Many of the nurses interviewed attended private fee-paying nursing schools and colleges. For these paying students, finances to support the costs of nursing training were obtained through bank loans and family resources, particularly those of parents as well as working siblings. Due to the cost of nursing fees particularly in private nurse institutions, the very poor would be unable to afford nursing fees unless they obtained government sponsorship. For example, Meena, a 59 year old nurse working in a private mission hospital told me that as she came from a poor family, her family would have found it difficult to raise the funds for the course. However, she was able to enter a nursing programme as the costs of her training were supported by the government:

Yeah, because they (her family) were not giving any money. So they were not worried about money. I got it in the free seat, so I joined.

'Getting a job'

An investment in a nursing education is considered to have high financial yields for nurses and their families, in that they are able to find a job relatively quickly and can contribute to family earnings. Neelam, a 53 year old government nurse told me about why she joined nursing saying "*in those days we had a tough time you know, so I thought 'okay, I'll join nursing'. Because in those days, we were not that well settled.*" Similarly, in her interview, Soraya explained that becoming a nurse would allow her to find employment 'anywhere'. She told me "*Wherever we go, we can survive, we'll live. Wherever we'll go,*

we'll get the jobs." Echoing these sentiments, Annie, a 32 year old nurse from Kerala spoke about how most of her friends turned to nursing because it provided direct access to employment and was also why she joined along with them. Annie recounted:

It's easy to get jobs. And if you go for a degree, and after getting one degree also people will be there without any job. So mainly we have selected because of this, it is easy to get jobs. That is the main reason we have selected this profession.

The attractiveness of nursing as an accessible 'job' has not only attracted women across age groups into nursing training, but also men, in that economic concerns exert considerable pressure on both men and women from lower income families to engage in a vocational course that offers a guarantee of employment. One of my first interviews was conducted with Professor Nande, the male principal of a nursing college, who told me that he knew little about nursing when he joined. Coming from an agricultural family with limited economic means, Professor Nande was interested in nursing training predominantly because it could provide him with a 'a job'. Similarly, Ajit, a young male nurse working in a private teaching hospital told me that he selected nursing primarily because it is a "*job oriented course*".

Most nurses did not provide much information about alternative jobs considered as they expressed an overall interest in nursing. A few respondents mentioned their initial interest in studying medicine but as they did not get the required grades, they entered their second choice of nursing. Some interviews yielded some information on what the peers of some of the female respondents were doing, thereby providing a glimpse into other opportunities available for women of a similar background. These 'alternative jobs' were usually talked about when comparing the salaries of nurses, which the respondents felt were very low, to the salaries of their friends working in other areas. For example, Malika, a 25 year old nurse working in a private hospital compared her monthly salary of 7, 500 Rs (£105) to that earned by a female cousin who was working in a travel agency:

Yeah, the pay scale, if we compare to other professions. For um, in our family, if you will take my cousin sister, she has completed her 10th. Then she took tourism as her, this thing. Now she is working for a travel agency. She is paid nearly 20,000 per month.

Similarly, Kumari, a 24 year old nurse working in the same hospital as Malika, compared her pay to that of her peers who were employed as teachers, "*... and then the salary is also, it is*

not that good. Like er, my friends they are working as a teacher and they are earning better than me.”

For male nurses, alternatives available or considered as attractive job options include engineering, management studies and working in the corporate sector. Thomas, a 24 year old male nurse from Kerala told me that he had initially thought about doing a management course but then opted for nursing upon the advice of his father:

See my plan was to do some management course or something like that. I mean, I was interested in nursing, but I had given preference for some management studies like that. And my father told ‘don’t go for all such things’ and this is a noble profession.’ Like that he told. Then even I didn’t have any problem so I said ‘Okay Dad, I will do that’.

Similarly, Santosh, a 25 year old nurse working in the same private hospital, had worked as a clerk in an accountancy firm after secondary school. Like Thomas, Santosh was encouraged into nursing by his parents who were keen for him to obtain a professional qualification. He consequently left his job and took up a government seat to join a GNM nursing programme. Santosh recalled:

My parents were not satisfied with my education as I didn’t have any qualifications, just after 12th standard (18 years) I was working, but I was very happy with the job, but they wanted me to be a professional, some profession kind of thing, so they advised me to be in nursing.

All but one of the male nurses interviewed mentioned the support of their families in undertaking nursing. Karthik, the only exception, was a 34 year old nurse whom I met at the private outpatient clinic. Karthik had already finished his Bachelor Degree in Commerce and had worked for five years in a private company. When he decided to enter a nursing programme, some of his relatives were against this as they felt that it would be too costly and already too late in his career to make such a switch. Therefore, their concerns were mainly due to changing career paths and the potential lost earnings that this would entail, rather than the view of nursing as being an ‘unsuitable’ job for men. In addition, Karthik's sister and cousin were already nurses and had informed him of the potential job opportunities for male nurses both in India and abroad. The perceived mobility of nurses was therefore a main factor in Karthik's decision to undertake a nursing qualification:

Bachelor degree means, that time I think I cannot move anywhere out of Kerala, there is no scope only for Bcom. But if I did the nursing course, I can go abroad very easily. So I changed my career. Also I wanted to improve my knowledge and get more money.

Consequently, although class considerations and the need to 'find a job' also serve as an important 'push' into nursing, these alone do not explain why nursing was selected above other available employment. Rather than being 'just a job', nursing was perceived as a way to access social and economic rewards particularly through migrating overseas and was therefore seen as a job 'with prospects'.

The 'pull' of nursing: a job with 'prospects'

For both male and female respondents, a key factor in the decision-making process to 'become a nurse' is the perception of nursing as a 'job with prospects'. Although migration will be discussed at length in the next chapter on career paths, the 'prospects' of nursing are particularly related to the view of nursing as internationally mobile, and the economic and social rewards that can be acquired through working overseas. Rather than being restricted to the narratives of younger nurses, the perceived benefits of becoming a nurse migrant cut across age groups. A number of nurses in their 40s and 50s whom I interviewed were return migrants, or were interested in working abroad. Nurses in their twenties and thirties were also keen to work overseas and, at the time of my interviews, a few had already taken their Registered Nurse (RN) and English proficiency exams required for the United States and were waiting for work visas.

Economic rewards

Nursing is not considered to be a well paid profession in India. In addition, the economic rewards of being a 'bedside' nurse in Indian hospitals were seen as being particularly limited. As will be discussed further in the following chapter on careers, working in nursing education is viewed by nurses as a more lucrative career path than a career in bedside nursing. Furthermore, nurses with BScs, Masters, PhDs and specialized diplomas are able to earn significantly higher salaries than nurses with GNM qualifications, particularly within India. This is not only due to the increased potential for promotion through the ranks of nursing management, but also being able to 'cross over' to nursing education and access a higher salary structure. However, the possibility of overseas employment for nurses with

either a BSc or GNM qualification is a major economic reward associated with becoming a nurse. Nurses were well aware of the international ‘nursing shortage’ and were keen to secure working visas in countries such as Australia, Ireland, the United Kingdom, the United States, Canada, the United Arab Emirates, Saudi Arabia and Qatar.

For many nurses, the economic rewards of a ‘foreign salary’ offered the possibility of building up savings that nurses could use to buy houses, support their families, invest in family businesses and put aside money for their ‘dowries’.³² Consequently, many planned to return to India after a few years and ‘settle’, where this term was typically used to refer to the prospects of a financially stable life. The following is an extract from my joint interview with Kumari, 24 years and Prabha, 25 years, both of whom were working in the private hospital.

- SJ: *And why would you go abroad? For the salary?*
Kumari: *Yes*
SJ: *or the experience?*
Prabha: *Experience also*
Kumari: *Experience also*
Prabha: *We got to know things better, like advanced technology. Like a few things we may not come across in India which we may come across in abroad also. That is also there. After that, salary wise, it will be helpful for us.*
SJ: *And how many years would you want to spend there?*
Kumari: *Two, three or four, not more than that.*
Prabha: *Within five, not more than that.*
Kumari: *At least with that we will be settled, we will be having financial stability. We will come back here, we will have our own money to study further or something, or if we’ve got to get our own house or something. We’ll be like, we’ll have something at least.*

Migration is viewed as a key strategy enabling nurses to ‘settle’. For example, when I asked Thomas what he planned to do in the future, he replied:

Actually, for all nurses, the hidden agenda is to fly abroad. My wish is to go abroad and to well settle. After that, I will come back and I will do something for the society.

Thomas’ reference to a ‘hidden agenda’ was not a literal reference to secrecy surrounding nurses’ migration plans, but was used to illustrate that among nurses, the desire to migrate overseas is very common and for some, is an incentive to joining the nursing

³² Dowry refers to the net exchange of all cash and in-kind gifts made from the bride’s household to the household of the groom at the time of marriage. Although the payment of dowry is a criminal offence in India and prohibited since the passing of the 1961 Dowry Prohibition Act, the practice is widespread among many communities across the country that observe endogamous marriage practices.

profession. I did not find that plans to migrate overseas were 'hidden' at all, nor did nurse migration constitute a touchy or sensitive conversational topic. Nurses were very candid about their future plans to migrate and the reasons they wished to do so. Many were equally candid about the reasons why they did not wish to work overseas. During my discussions with nursing superintendents, nursing principals and medical directors, I was informed that nurses regularly request time off to attend interviews and take the relevant exams for nursing overseas. Also, during my site visits, I met a few young nurses who had just come back from interviews that day, including two who had received letters of acceptance for employment in the Middle East. On a few occasions, I was informed of these plans by the nurses concerned in front of their supervisors.

Social rewards

In addition to the economic potential of 'international nursing', entry into the profession is also perceived as leading to increased social benefits, particularly in terms of knowledge, experience and status through becoming a 'nurse migrant'. A few respondents specifically mentioned their desire to 'learn about new cultures' and 'gain knowledge' through working abroad. The desire to 'gain knowledge' was used both in the sense of improving nursing knowledge and skills, as well as learning more about 'the world'. For example, when I asked Lizzy, a 27 year old nurse from Karnataka why she was interested in working abroad, she replied:

Erm, I told no, I am really one of the ambitious people and I want to travel all over the world. I want to know the customs and religions of those peoples ... Not only that one, but how is the hospital facilities abroad and in India. We have to compare to know about it. One more thing, we have to earn some money from there also.

Becoming a nurse migrant brings a particular set of social benefits for women. Marie Percot, in her research on female nurse migration from Kerala, discusses how a nursing diploma is regarded by female nurses and their families as an opportunity to increase social mobility and is therefore a 'life strategy' for young Keralite women. Her interviews with nurses migrating to the Gulf illustrate how migration offers women better marriage prospects, greater autonomy than in Kerala and increased status through living the life of an 'NRI' (non resident Indian). As Percot (2005) writes:

The NRI (Non Resident Indians) as they are called in India are actually seen, by most Indians, as a lucky sort of citizen who in a certain way get the best i.e. an Indian cultural heritage added to the material advantages of more prosperous countries.

Percot argues that for ‘nurses to be’, the perceived benefits of becoming a nurse migrant are very powerful in encouraging entry into the profession, where nursing becomes the ‘passport’ to this way of life (Percot 2005). Percot also found that the status given to female nurse migrants translated into higher value in the ‘marriage market’ in that nurses became actively sought as marriage partners for young Keralite men.

The increased marriage prospects for women through obtaining a nursing qualification were also highlighted in some of the interviews and informal discussions particularly with nurses from Kerala. During an initial visit to one of the private hospitals, I engaged in a discussion about the image of nursing with Dr Tandekar (the medical director) and Sister Annie (one of the nursing supervisors) both of whom came from Kerala. They told me that nurses are now seen as ‘marriage opportunities’ by young men and their families as they are mobile and offer the possibility of employment abroad for themselves and their spouses. A similar discussion also took place in a joint interview with Annie and Sister Josephine, the nursing superintendent.

- SJ: So the Keralite nurses, they go abroad and earn money and come back to India?*
- Josephine: They can earn money for their wedding or for the future expense. Even they can construct good houses. The total life atmosphere will be changed. And even nurses, boys are also looking now. Those who have passed the IELTS (international English language testing system), that everything they see now.*
- SJ: So you are saying that the boys are looking for nurses?*
- Josephine: yeah, yeah*
- Annie: If you see the ads you can see the difference. Earlier they used to ask for a good looking girl and things like that. Now you have the ‘good looking’ but also BSc, GNM, working abroad. If they are working in India, if they have passed the IELTS exam. They are giving preference to all these things (laughs)*

In Kerala society, dowry payments tend to be considerable and, although negotiable, often include money, jewellery, property and/or other family assets. For young female nurses, in addition to being able to raise funds to support dowry payments, a nursing qualification is also considered an important dowry asset that can offset some of these costs and secure a suitable partner. Percot found that being a nurse allowed young women to reduce the price of

the dowry asked by the future in-laws as the earnings of the bride would add to the income of the in-laws, particularly through migration (Percot 2005). Some respondents from other southern Indian states highlighted that the payment of dowry was not as pervasive as in Kerala. Sister Josephine, who comes from Tamil Nadu explained:

See Malayalees (Keralites), the girls, they have to give a lot of dowry. So, one profession in which they can earn more money that is nursing. They don't wait at home without a job. They can get a job immediately. They can go abroad, earn, and take care of everything and their families. That is what has been happening. See, even from their childhood, they start keeping money, to give the dowry. But Tamilians and all, they don't.

The increased attractiveness of nurses as marriage partners is also due to other status markers such as educational achievement. As Lakshmi explained:

Lakshmi: 'Aaaaah. Nurse eh?' they used to say. But now doctors are coming to marry nurses. Now in the last ten years.
SJ: Do you think that is because of nurses moving abroad?
Lakshmi: No, they are well educated. Equal. There is also four years of training, four years of BSc and two years of PhD. They are also doctors.

Another key benefit attached to becoming a nurse that was particularly mentioned by older female nurses is that of 'independence'. For example, retired nurse Sophie described being greatly influenced by the vision of nursing created by her peers - that of an exciting, 'glamorous' life:

And all my friends were nursing. They were so happy and they would come and give us such glamorous accounts of the, you know how they used to allow them to go out with boyfriends and dances. With the nuns we had to be back by 6.30 in the evening.

The perception of nursing as a 'job with prospects' is perpetuated by the living example of friends and family members who are already nurses. These nurse 'role models', particularly within the family environment, are key agents in encouraging other younger family members in joining nursing, thereby creating a kin network of nurses. I refer to these kin networks as 'nurse families'.

Nurse families

The interview testimonies indicate that it was largely the influence of female friends, neighbours and family members who were taking up nursing that served to reinforce its image as a 'suitable' job for women. As the interviews progressed, I often heard '*my mother/sister/aunt is a nurse*' as a reason given as to why a number of my interviewees were interested in nursing and why they had decided to join the profession. These responses most often presented entry into nursing as a natural choice of employment as it was a path already being followed by other female friends or family members. For example, when I asked Ashwani, a 23 year old nurse from Kerala why she decided to enter the Diploma nursing programme, she replied "*No decision. My sister was a nurse*".

Through the data, I began to see a link between nursing as a traditionally gendered occupation, and the creation of 'nurse families' where, for many of the nurses interviewed, female family members such as mothers, sisters, cousins and aunts were also nurses. In India, as in other Asian contexts, the concept of 'family' is more extensive than the more Western model of the 'nuclear family'. Consequently, distant or marriage related members ('in-laws') are also included in understandings of family.³³ My interview with Sophie and her daughter Joy during my preliminary fieldwork was my first exposure to the phenomenon of 'nursing families' in India and the influence that nurse 'role models' have on the decision of younger family members to enter nursing. Joy told me that Sophie was the main influence in her decision to become a nurse, where she 'followed in her mother's footsteps':

SJ:

Joy:

And why did you go into nursing?

Well, I think I have always been, you know, inclined to work at the hospital, the choice was between medicine and nursing and I think I went into nursing mainly because my Mum was a nurse and I sort of followed in her footsteps. We went to the same school, we went to the same school and nursing school, both of us were, we did exactly the same.

Malika, a 25 year old nurse from Kerala told me that her aunts offered her an initial insight into nursing:

When I was a kid, I used to watch television. That time if anybody asked me when I was er six years old, what will you be when you will be grown up like that, ah, I will be an actress, I will be an actress only. My mummy's sisters, both of them were nurses.

³³ Male and female cousins, for example, are also typically referred to as 'cousin brothers' and 'cousin sisters'.

I used to see them wearing the uniform when I used to go to meet them in the hospitals I would see them with the patients, with injections, trolleys and then I saw er, they went to the Gulf, those years from 78 to 88, I'm sorry, 1988 that time. So, a little bit of this was there, if I will be able to do, I will practice nursing only, like that.

In the interview set, twenty nurses specifically mentioned the presence of at least one other female relative who was a nurse. Some nurses, like Lakshmi, came from large nursing 'families':

Laksmi: All of our family, all of us four sisters are in nursing only. My elder sister, she too was a nurse, second sister also a nurse and the third. I am the 7th of the family.

SJ: Oh, so you have four sisters?

Lakshmi: Four sisters and two brothers. And I am the 7th one.

Many of the Keralite nurses interviewed were from 'nurse families', where ten out of sixteen nurses originally from Kerala talked about other female family members who were nurses. This appears to be largely due to the long history of nursing in Kerala and the patterns of recruitment traditionally among the Christian community, many of whom came from Kerala. As Sheba George notes, these communities were relatively more open to women working outside the home than other religious communities (George 2005). The following is an extract from my interview with Rita, a 29 year old Keralite nurse:

SJ: So, where are you from?

Rita: Kerala.

SJ: Ah! So Kerala has lots of nurses?

Rita: Hah! Lots of nurses! In one family, at least one nurse is there.

SJ: And in your family?

Rita: In my family, total four nurses (laughs)

SJ: Who are the nurses in your family?

Rita: My elder sister and two other sisters-in-law (laughs).

The development of 'nurse families' serves two important functions in influencing the decision of younger female family members to join nursing. Firstly, it presents nursing as a feasible, accessible and appropriate source of employment. For example, as Kumari told me:

My sister, my elder sister is a nurse. Actually, like, looking at her, I thought it is good to be a nurse, like a profession like, financially wise. I thought it is a stable profession to be in. So I chose to be a nurse.

Secondly, for many of the respondents, it is these female nurse 'role models' in particular who provide an initial view into the world of nursing and help mould the expectations of the possibilities and experiences that nursing can bring.

Nurse role models

Nurse role models actively encourage an interest in nursing among younger family members particularly through persuasive discourse around the opportunities and benefits of a nursing life. When I asked Suzanne, one of the teachers at a nursing college why she had selected nursing, she replied:

Because I was influenced by my mother. And, I always kept her as my role model you know and she used to come and tell me about patients when she was feeling satisfied with working with them, and she used to tell me all that, and I was really fascinated, but then she was the person who influenced me more.

The interview narratives demonstrated that the persuasive power of the nurse role model(s) in communicating the prospects and benefits of embarking upon a nursing career was very influential to the decision of many respondents to enrol in nurse training. As we have seen earlier, some respondents were pressured or encouraged to switch from their initial choices into nursing. Lizzy, a 27 year old nurse from Karnataka told me:

Because really during that time I was not interested in this profession. I wanted to become a teacher. Then, one of my aunts, she is a nurse in one of the...she told me that nurses earn so much good opportunities, because it is one of the noble professions if you finish the course you can go anywhere in India, anywhere in the world, like she told. She gave some encouragement to me. Then I changed my plan and I was joined to the nursing.

The persuasive discourse about encouragement into nursing by a nurse mentor was not experienced only by female family members. Three male nurses came from 'nursing families' and two highlighted that they were encouraged by nurse mentors to take up nursing because of the increasing scope for men in the profession, especially through working abroad. As Karthik recalled:

My sister is a nurse. And my cousin is working in the UK. She told like that 'go to male nurses, it is a very good chance for male nurses in the UK and other foreign countries.

In addition, the role of 'nurse role models' is not just visible in influencing family members to join nursing. As social networks in India tend to be more communal and not just limited to the immediate family, this may explain why the role model influence sometimes extended to the mothers and sisters of childhood friends as well as to neighbours and family acquaintances. In her interview, Savitri gave a very vivid account of the influence that her best friend's mother had on her decision to become a nurse:

I belong to the Hindu religion. I have a very close friend Mary from the Christian community. We were very close friends ... So, her mother was a nurse in X town. She used to go once in a while to meet her mother ... So once I accompanied her to see her in X hospital. Maybe we were 15 or 14 years like that. So that I time I had gone and I saw the nurses going to the wards and coming back from the wards and then going and taking the patients. We were with her mother for some time. For about half a day or something like that. It was mainly, you know, patient care touch and you know, the uniform, pure white and good, beautiful looking, like angels, big big, you know, veils and other things. It really impressed me.

For those coming from non-nurse families, however, entry into nursing was not always easy. Despite being inspired by Mary's mother, Savitri's family was against her decision to enter nursing and wanted her to become a doctor. Similarly, Karishma, a 54 year old nurse from a high Hindu caste in Karnataka, told me that she was initially inspired to become a nurse when she was ill with tonsillitis as a child and was admitted to hospital. She saw the nurses in "full uniform" and was attracted to the idea of nursing. However, she faced opposition from her father who wanted her to be an ayurvedic doctor or a lawyer. In addition, Karishma also had to overcome some of her own prejudices when she began her nursing training, explaining "Because in some religions, so much dirty and all. We are hesitating to touch them. That is our mentality". Consequently, unlike nurses from 'nurse families', who are already following an accepted path, 'first timers' particularly from better off families often have to negotiate some of the public images of nursing that render it an 'unsuitable job'.

Changing images of nursing

As nursing was traditionally considered to be low status work, concerns about caste pollution through providing physical care to patients as well as interaction with men who were not relatives, meant that nursing was viewed as unsuitable for high caste Hindu women, as well as Christian and Muslim women from an upper-class background. Examples of negative attitudes towards nursing came out most strikingly in the interviews of nurses in their

40s and 50s. For this generation in particular, nurses had to struggle against prevalent attitudes towards the profession that gave it a 'bad name'. For instance, Vandana, a 58 year old nurse from the high caste *Nair* community in Kerala pointed out:

Before also, nurse means bad name (laughs). Bad name! Because in a hundred members, one is okay, really. In my house there are not sending. Because nurse means bad name. If in Hindu families there is a marriage proposal, she is a nurse, bad. But if it is a Christian, it is okay. That is the difference, Hindu and Christian.

The above quote suggests that that there may be a perception that as nursing has Christian roots, entry into the profession is unproblematic for Christians. Interestingly, however, the association of nursing with 'dirty work' was also shared by respondents from a Christian background as well as those from Hindu families. Miriam, a 43 year old Christian nurse from Kerala explained that once her father died, she was looked after by her paternal grandparents. As they could not afford the costs of higher education for all of her six brothers and sisters, nursing training offered a lower cost vocational alternative. However, her maternal grandparents were very unhappy about her decision. She explained:

So then, everybody who is in nursing, means that we should have to care and change dirty dressings. This is the mentality in that olden days. So actually, when my mother's parents found out, they so much rejected me 'don't go' like that, it's not good.

Although Miriam's maternal family eventually accepted her entrance into a Christian mission hospital, they were initially concerned about the moral standing of nurses where "*they had the idea that the Bishops are running around with the sisters and all*". Similarly, Parvati, a 34 year old nurse from a scheduled caste Hindu family in Karnataka told me that her mother was not supportive of her decision to become a nurse because of the questionable image of nursing. However, her father supported her choice as he worked in a government hospital as a technician and was familiar with the work of nurses.

In terms of contemporary images of nursing, although a few respondents complained about being 'looked down on' by some members of the public, there was a general feeling that the image of the profession in the public consciousness was beginning to change. The higher social status of nurses than that of previous generations was seen as being largely due to greater public awareness of the work nurses do and acceptance of nursing as a profession in its own right, rather than informal domestic work. Nurses also felt that the public was

beginning to notice their increased economic potential through the possibility of overseas employment. Parvati explained:

Nowadays I find that people are coming up. People are coming up and they are talking something good about the nursing profession. It could be because of the knowledge wise and also because of the job placement. Most people perceive of nursing in virtue of this job placement. Because they find that when you do nursing, you can earn your bread without much difficulty. Because you can get a job anywhere, in any part of the world.

Perhaps the most visible marker of this change is in the marriage market, where female nurses previously found it more difficult to secure a husband. As discussed earlier in the chapter, the growing perception of nursing as a 'job with prospects' has led to nurses being seen as desirable marriage partners through their ability to work abroad, earn a foreign income, and to secure foreign work permits for their spouses. The changing image of nursing has also started to encourage the entry of communities that were previously absent from the nursing profession, such as Muslims and high caste Hindus. Sister Josephine explained:

The public, see initially they were thinking that nursing is low. But now they are more aware of what is nursing and they have also started respecting the nurses. Nowadays they have a good opinion on nursing. See previously, it was only Christians who would go for nursing. Now it is Muslims, Hindus, and especially among Hindus, Brahmins, they were not going. Now a few are there. See they know that this is a better way to earn money. That is the main thing.

Karishma, who comes from a high caste *Lingayat* family in Karnataka also agreed that there had been a change in attitude since 'her time'. Traditionally, nursing would not have been considered a suitable job for a woman from her community. However, with regard to the changes even among those of her caste background, she noted:

Long back that attitude was there. Now it has changed. Because easily we are getting jobs anywhere. So now all religions are coming and liking this profession. In the beginning in our time, that was very difficult to choose it. Now it has been changed.

Karthik also agreed that the previous 'bad name' of nursing had given way to a more positive public perception due to increased knowledge about what nursing is, and the job opportunities available. His account also suggests that this may be the reason why men are increasingly entering the profession.

Earlier in the beginning stage, only ladies were going to the nursing profession. Then I think two or three years back only, the boys are going into nursing. And in the beginning means bad name to the nursing, it is a very neglected job or something. But nowadays, people have realized the job opportunities and the service to the people. Some people like the service to the people. Actually, the nurses have a good chance to service to the people and also get the benefit from the God also.

Given the popular negative images of nursing and nurses which were particularly prevalent during the time older respondents entered the profession, a key question emerges as to why these nurses actively chose to enter the field. This has been answered to a large degree in previous sections which discusses the attraction of the job related benefits of nursing for those coming from more financially constrained circumstances or with few other available choices. However, another pervasive theme which emerged in the interviews is alluded to by Karthik in the interview extract above. In their narratives, I found that many respondents across age groups and backgrounds highlighted the characteristics of nursing as a ‘noble’, service-oriented profession. For these nurses, this image of nursing as a ‘vocation’ became a powerful source of personal inspiration.

‘A noble profession’

In a number of interviews, respondents used vocational language when accounting for their decision to enter nursing. For example, they often referred to nursing as ‘a noble profession’ and specifically told me how they wanted to ‘serve the poor and the sick’. Nurses frequently invoked the notion of nursing as a ‘service’ or ‘calling’ and in doing so, presented their decision to become a nurse as a moral choice alongside more ‘practical’ issues such as the necessity of finding employment. For example Soraya told me that in addition to being able to secure a job through nursing, she was attracted to the possibility of performing a service to society:

In nursing we can serve people and there more career opportunities ... And we can serve people, whoever it is, rich or poor. We can give our serving hands.

Initially, I treated these narratives with some scepticism as I wondered whether this language was being used by my interviewees to portray themselves as being of a high ‘moral character’. As the interviews progressed, I came to appreciate the sincerity of these accounts,

and that for many, the idea of nursing as a ‘morally worthy’ profession is an integral part of being inspired to become a nurse.

Many of the narratives revealed an emphasis on performing a ‘service to mankind’ and ‘helping the poor’ that follows a more Christian value system. Rose, a 45 year old nurse referred to her Christian beliefs as being the main influential factor in choosing nursing as her profession:

I am a Protestant. One bible verse made me to select this profession. In that the lord is telling to the disciples ‘if you take care of the people who are in need and if you are helping them, if you are attending to them, these things you are doing for me.’ See if I am doing things for any people in need it could be ... (inaudible) ... the bible verse says that if you are doing for the people in need, you are doing for myself. That is what the Lord says. That basic verse made me get involved with nursing practice.

However, the accounts of some Hindu nurses also had echoes of Christian spirituality. For example, Bhavna, a 29 year old Hindu nurse working in the private teaching hospital told me that it was her ‘dream’ to become a nurse:

- SJ: And could you tell us what attracted you to nursing? Like why did you decide to become a nurse?*
- Bhavna: It was my dream actually.*
- SJ: Really?*
- Bhavna: When I went to a nursing home and all in X when I’m studying that time I saw the sisters and I would like to do something, to give the service. I think we will get very rare chance doing some, this type of service, being nurses and all no? That is one ambition.*

Deliberate reference to these values, regardless of the religious background of the nurses, may have been shaped by their training experience, where many studied nursing in Christian institutions or were taught by Christian instructors. The narratives therefore may indicate some effects of learned narratives where nurses are reproducing in retrospect what they learned at nursing college about the inherent vocational values of nursing. However, a vocational discourse was not only employed in explaining the decision to enter nursing, but was used throughout the interviews, including in descriptions of nursing work and accounts of job satisfaction suggesting that there was a strong belief among my respondents in these values. Sarita, who had been a reluctant recruit to nursing, told me how she had come to love her work, particularly because of the ways in which she was able to provide a ‘service’ to those who needed it. She noted:

And then Mum was right in putting me into this profession because you have a whole lot of opportunity where you can cater to different types of people who are really in need and during their worst crisis. So that's when I really started loving the profession and I thought it was a great thing to be a nurse.

'Inspiring incidents' were also used in the narratives to describe personal encounters with nurses and nursing that demonstrated the noble character of nursing. These typically included descriptions about being inspired by the care provided by nurses when the interviewee or interviewee's family member had been admitted to hospital. For example, Grace, a 36 year old nurse from Karnataka talked about her experience after being admitted to hospital as a school girl:

Once when doing my second year of my PUC (pre-university course), I was sick, very badly. So, I was admitted in a hospital for one month. So the way the nurses were taking care of me, I thought that I too have to take care of the patients this way only. So I thought at that time to become a nurse and to serve the patients.

For other respondents, it was the role model of Florence Nightingale who personified nursing as a noble profession. For example, Sophie referred to her admiration for Florence Nightingale several times during her interview including when accounting for her decision to enter nursing training:

When I was a young girl, before I left school, I made up my mind to be a nurse because, you know, I always er, when we heard about Florence Nightingale in school I was very touched. She was so kind, even to animals when she was small, and then when she grew up she went and helped on the front during the, first world, or er Crimean war.

In her narrative, Sophie often referred to Florence Nightingale with relation to certain characteristics that nurses 'should have' - such as "being dedicated" and "doing work with love." Her emphasis on these traits illustrate how for her, nursing as a vocational calling is an integral part of 'being inspired' and key to being a nurse. Rather than being 'just a job', Sophie described nursing as a central part of her self-identity:

It's not for money or anything, but to look after the helpless so we have to do our work with love for the helpless. That is what I did and I was really, I really loved it, and till today I tell everybody I'm a nurse. I'm very proud of it.

For a number of respondents, early childhood memories of watching their nurse role model at work, dressed in their white nursing uniforms, served as inspiration to take up nursing later. Pat Holden, in her study of nurses in Uganda, highlights how the prestige and recognition attached to a nurse's uniform is related to the image of 'order, discipline and morality' perpetuated since the days of colonial nursing, and in this respect serves as a reminder of a more 'ordered' past (Holden 1991). Holden describes how despite the hardships experienced by Mulago hospital in Kamapala during the 1980s through a lack of infrastructure, equipment and an insecure environment, nurses employed in the hospital continued to perform a visible service in their 'beautifully laundered uniforms'. She writes:

Visitors to Kampala and others comment on the way in which nurses continue to turn up for work at the hospital looking so well dressed. In the nurses' hostel, now an almost derelict building, the laundry room is kept in good working order. (Holden 1991: 78)

As in Uganda, the nursing uniform in India is also a result of India's colonial nursing history and, through its Christian associations, is symbolic of the notion of providing a 'service'. Some nurses described their initial impressions of nurses as looking 'like angels' and recalled being attracted by the white colour and the veils associated with the uniform. Devi, a 57 year old Hindu nurse from Kerala told me:

See, er my grandmother was admitted to X district hospital. I don't know at that time how many years I were in my age. But when I went to that hospital the sisters were wearing white uniform (laughter). And these people are running here and there and these people were serving the sick people. Then I liked the sisters' uniform and the nursing profession. Otherwise my parents did not like to send me to this nursing profession. So, I liked this profession and I want to serve the sick people so I came to this profession.

Devi also recounted her dismay when the hospital management considered replacing the traditional white nurses' uniform with 'pants and a shirt'. She recalled how at the staff meeting when this plan was announced, she stood up and said "Sir, till my retirement I want to wear this uniform only. Because I like it. Wearing the pants and shirt no, I don't like it". Consequently, for many in the profession, the nurses' uniform has an important function in that it is easily identifiable and symbolic of a distinctive identity - one that is based on the expression of devotion, service and duty.

Summary

The importance of nursing as an occupation that is heavily influenced by gender and class considerations has led to the emergence of 'nurse families' in which nursing is an inter-generational female trade. In this sense, nursing has moulded itself into the traditional system of social stratification in India, in which historically, one's occupation was largely inherited. In this patriarchal system, however, occupations were passed through the male line with women's work largely limited to the domestic sphere. Nursing is therefore an important example of a female dominated occupation that has historically offered Indian women the possibility of independence and financial stability.

Nursing in contemporary India offers an 'attractive package' for young women and for increasing numbers of young men. For many respondents, the notion of nursing as a 'suitable job' is dependent upon the range of opportunities available as well as their gender, class and family background. Such indicators of social stratification are not static categories but frequently evolve and interact as societies develop, including in traditional contexts undergoing fairly rapid social and economic transformation (Stivens 1998). It is therefore unclear whether nursing will offer the same set of 'prospects' and opportunities for the next generation of nurses. This is also because such 'prospects' are linked to macro economic and political issues beyond the world of nursing, such as immigration and debates over work visas for foreign nationals. With reference to her study on nurse migrants from the Philippines, Catherine Choy points out that migration is inextricably linked to the larger processes of global restructuring where the increased demands for goods and services has contributed to international mobility (Choy 2003). It therefore remains to be seen whether the factors that designated nursing as a 'suitable' job for their mothers in particular, will hold true for their children. However, within India, the changing image of nursing and perceived economic opportunities has attracted a number of 'new recruits'. It is certainly possible that this trend may continue and contribute to an expanding pool of nurses beyond the traditional Christian nurse 'heartlands' of the south and outside existing 'nurse family' networks.

In the next chapter we shall take a more detailed look at migration as well as other career decisions typically contemplated by nurses working in Bangalore's hospitals. We shall examine how careers are constructed and discuss the emergence of career linked 'identities' in nursing.

Chapter 4

Career pathways in nursing

The concept of a 'career' is typically used to describe the work experiences of an individual throughout the course of his or her life (Wilensky 1961; Hall 1976; Arthur et al. 1989, Mitch et al. 2004). Sociological studies of 'careers' have not only looked at careers as a series of occupational roles but have also used the notion of a 'career' as a framework to study the life histories of TB patients, juvenile delinquents, marijuana users and the insane (Shaw 1931; Goffman 1961; Becker 1963; Roth 1963; Waldorf 1973). Despite this broad definition and scope, the corpus of theories related to the construction of a work career have been criticized for their emphasis on white collar workers and for being predominantly modelled on the experiences of white men in Western societies (Gallos 1989; Thomas and Alderfer 1989). Feminist scholarship has gone some way to redress this by analysing women's relationships to wider social structures and their impact on the nature of employment choices available to women in the construction of a 'career'. This approach has challenged patriarchal notions of where careers are located (i.e. as being limited to the 'public' work arena), and seeks to embed career decisions within a broader life development framework that values the roles and experiences of women rather than exclusively focusing on those of men (Marshall 1989; Gallos 1989).

As theories of careers have been developed in Western, industrialized countries and typically describe an individual's relationship to organizational culture, exporting the term 'career' to non-Western contexts requires some thought as to the universal suitability of this term. Most understandings of 'career' in Western contexts take the individual as the primary agent of analysis and thus assume an individualistic approach to decision-making around work. As this assumption may not translate well in the Indian context, I initially viewed the wholesale application of the notion of a 'career' to the work histories of nurses in the study setting as being somewhat problematic. However, the term 'career' was often used by nurses and thus was an important emic construct. Its frequent use in the interviews to describe employment pathways through nursing suggests that the concept of a career has cross-cultural acceptance. Consequently, the pervasive reference to the notion of a 'career' by interview participants in addition to its broad usage within the social sciences, presented a compelling

case for its use as a framework within which to examine the occupational roles and life choices of nurses in the study.

In the following chapter, I therefore discuss the ways in which nurses forge a career through nursing in the study setting. In particular, the chapter examines the desired outcomes of career choices and how career decisions become part of the construction of distinct professional identities in nursing. The chapter begins with a brief overview of the typical structure of the nursing hierarchy in hospital settings, including the initial transition from student nurse to an entry level hospital staff nurse position, followed by steps up the hierarchy into nursing management. As career decision-making begins with the choice of a BSc or GNM nursing programme, the chapter examines the career expectations of holders of a GNM Diploma or BSc Degree in nursing. This is followed by a discussion of other major decisions in building a career in nursing and includes the choice of clinical speciality, working in a public/private setting and the function of migration as a career strategy.³⁴ Finally, the chapter highlights the importance of networks for finding suitable employment opportunities in nursing and the cultural importance of communal decision-making in constructing a nursing career.

The nursing hierarchy

At each site, except for a few additional rungs for managerial positions at some of the larger hospitals, the nursing hierarchy was very similar. The key steps through this hierarchy typically involved the initial transition from newly graduated *student nurse* to *nurse intern*, which is the entry level position for recently qualified nurses. Not all nursing students opted for an initial hospital placement, where some nurses with BSc qualifications went directly into nursing education. An initial hurdle for nursing graduates first exposed to hospital settings is managing fear, particularly the fear of doing harm, or not responding appropriately in an emergency. Consequently, some newly qualified BSc nurses sought employment as teaching assistants in nursing colleges and schools after completing their degree and related this decision to their lack of confidence in their nursing knowledge and skills. For example,

³⁴ Although entry into nursing education can be viewed as a distinct career path, teaching can be located either within the public or private sector or in teaching hospitals overseas. For example, two of the nursing principals were employed as nurse educators in hospitals in the United Arab Emirates. In addition, as entry into nursing education is open only to those nurses with BSc and higher nursing qualifications it is not discussed as a separate career strategy as the majority of study participants held GNM nursing qualifications and most saw their careers located within clinical settings.

Prabha told me that she opted to enter nursing education following her BSc as she was 'scared' of providing patient care. She recalled:

When I was a student doing the bedside, patients used to come during an emergency and I don't know how to handle that situation. I was literally scared of that. So I thought that I am not ready for this even though I have completed my course. When any critical condition arises, I panic for myself sometimes, and I'll not be in a position to handle things. I thought it is better that I go into teaching rather than going into bedside.

As Prabha wanted to seek work abroad, experience working in a hospital was required and therefore she left her post as a tutor to join a private hospital. Prabha explained that once she 'got used' to providing patient care, she was able to overcome her initial fears:

Once I got in, the first 3 months I had a problem, then I got used to it. Now I like to work here in the practical side. I feel comfortable more than in teaching. It's nice caring for the patient. Most people are very happy with us, when we go in they convey their regards to us and say 'thank you' for whatever you are here for. So, we will feel happy and satisfied.

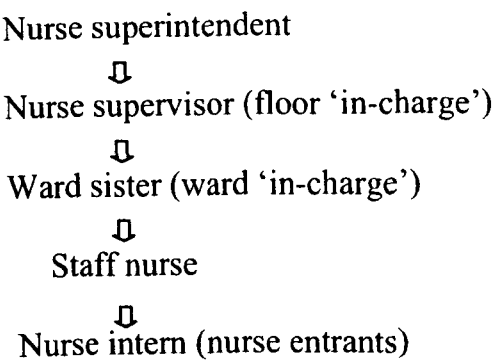
The learning curve for student nurses and the subsequent transition from *student nurse* to *nurse intern* is therefore mainly focused on gaining confidence in applying clinical knowledge in working with 'real patients'. After a period of 1-2 years in which the nurse intern is located predominantly on the wards, the nurse intern is promoted to *staff nurse*, a position that nurses typically occupy for a number of years and includes postings in different clinical specialities and settings (such as the Operating Theatre and the Intensive Care Unit).³⁵ The next grades up involve increased managerial responsibilities and were referred to by the respondents as *in-charges*. These include *shift*, *ward* or *floor* in-charge posts where a staff nurse 'supervisor' manages one or more patient wards and other staff nurses. Above the nurse 'in-charges' is the *nursing superintendent* or *nurse matron*, typically a highly experienced nurse who reports directly to the medical director or chief hospital administrator. See Figure 1.

Of the nurses interviewed, relatively few had climbed significantly up the nursing hierarchy. Most promotions were from staff nurse to an 'in-charge' post, where nurses took on administrative and/or managerial duties and supervised nursing care in one or more wards.

³⁵ The periods of time during which respondents worked as staff nurses ranged between five and fifteen years, before being designated management functions.

Nurse Matrons or Superintendents³⁶ were not always drawn from among senior nurses within the internal hierarchy, but were frequently hired from other hospitals. Consequently, for most nurses, career pathways mainly involved a lateral succession of posts in different hospitals and teaching institutions, clinical settings, and for some, stints abroad. Consequently, these lateral trajectories were found to be important to the construction of a career in nursing in the study setting.

Figure 1: *Example of nursing hierarchy*



Choice of nursing qualification: GNM or BSc?

There are two types of nursing qualifications for registered nurses in India - the Diploma in Nursing and Midwifery (GNM) and a Bachelor Degree in Nursing (BSc). In addition, MSc and PhD programmes are available as are several certificate and diploma courses in nursing specialities such as nursing administration, psychiatric nursing and others. For GNM nurses who wish to ‘upgrade’ to a BSc nursing qualification, a two year ‘post certificate/post basic’ baccalaureate course is offered at nursing schools and colleges, and can be undertaken via distance learning.

The majority of nurses interviewed across the hospital sites held a GNM qualification. A smaller number of participants held BSc nursing degrees, some of whom had upgraded from a GNM Diploma. Two nurses had also undertaken specialized diplomas in psychiatric nursing and one nurse had obtained a diploma in nursing administration. A BSc nursing degree is a higher qualification than a GNM Diploma and is required for entry into MSc and doctoral programmes, as well as to join a teaching faculty in nursing schools and colleges. BSc nurses also have a different pay structure where they are generally paid higher salaries at staff nurse level than their GNM colleagues.

³⁶ Heads of nursing were interchangeably referred to as either Matron or Nursing Superintendent.

In the interviews, nurses were asked why they had selected a BSc or GNM nursing qualification. For the majority of GNM nurses, there was not always a 'choice' between the two programmes, as entry into the degree course was mainly based on whether the BSc course was available in their area,³⁷ whether they had studied science subjects at school and their examination results. For example, Malika, a 25 year old nurse working in a private hospital told me that she had tried for a BSc nursing degree but was unsuccessful as she did not get the required marks:

SJ: And which degree did you do? Did you do the GNM?
Malika: GNM. Basically I tried for BSc nursing but in Mumbai, only X University had BSc nursing... Er that university, see the interview was over, but they had some percentage limitations, so I was not selected for that. And I had to join for GNM ...

BSc nursing programmes are also more expensive than Diploma courses and can cost between 1-2 lakhs of rupees per year (approximately £1,500 - £3,000) as opposed to 70-80,000 (approximately £1,000) rupees per year for a GNM course. Rani, a 28 year old GNM nurse, mentioned cost as being the main reason why she was unable to take up a BSc degree.

SJ: After the completion of your PUC, why did you choose GNM not BSc?
Rani: Means I need more money. Even now I have interest to pursue BSc, means at home I have more sisters and brothers. If I chose to go for BSc, who would take care of them?
SJ: Is it costly?
Rani: Yes, it is costly.

For the majority of BSc nurses interviewed, a degree course was purposely selected so as to provide more flexibility in career opportunities, such as being able to follow a teaching path or to enter further education in nursing such as through entry into MSc nursing programmes. For example, in the interview extract below, Kumari and Prabha contrast the flexibility of the BSc degree with the GNM Diploma course which they perceive as limiting nurses to hospital nursing.

SJ: Did you both do a BSc?
Kumari: Yes
Prabha: Yeah. It will be more flexibility. If you do a Diploma course you have to go only for bedside. If you want to go for higher studies, again two years we have to study ...

³⁷ Some nurses mentioned that BSc programmes were not available at the institution in which they trained.

In terms of career progression, a 'glass ceiling' is associated with a GNM diploma. GNM nurses are mainly limited to clinical settings unless a two year 'post-basic' nursing course is undertaken that allows for the upgrading of their nursing qualification to that equivalent of a BSc degree and thus opens up the possibility of entering nursing education.³⁸ GNM nurses also find it more difficult to obtain nursing management posts and therefore remain staff nurses for much of their careers. A few of the nurses interviewed had worked for more than 20 years as a staff nurse before being promoted to more senior 'in-charge' positions. Although GNM nurses can receive specialized 'in-service training' in their hospitals, as was the case in one of the sites, this is not a formal qualification as such but rather an internal requirement of the hospital. Nurses holding GNM diplomas therefore often expressed their desire to undertake the post basic certificate course to convert their GNM qualification to a BSc. Annie is one such nurse who told me that without a BSc qualification it was very difficult to rise through the ranks of nursing management.

... I have all these years of experience but only the years of experience won't be considered. If you want to get to the next position, if you want to get any promotion and all you have to, they will see the qualification also. Even with the general nursing only it is not possible to get any higher posts like that. So even at least BSc should be there to get even the nursing superintendent post. And even if you want to go beyond that, you have to again do the MSc nursing and all. So, I have to come up like that.

Holders of BSc nursing qualifications are also able to seek nursing employment in a wider range of countries than those with a GNM nursing diploma. For example, candidates for nursing employment in the United Kingdom and Australia currently require a BSc nursing degree in addition to proficiency in English and a required period of work experience. Other countries such as the United States accept both GNM and BSc qualifications, but candidates are required to sit the CGFNS (Commission on Graduates of Foreign Nursing Schools) exam followed by the NCLEX-RN exam to obtain a US nursing license as well as possess a minimum number of years of clinical experience.

Following admission into hospital employment in Bangalore, respondents with both GNM and BSc qualifications highlighted their desire to specialize in nursing training rather than becoming a 'general nurse', a term that was used to describe essential adult nursing care. Although in one site (the private teaching hospital), nurses were routinely transferred to

³⁸ To work as faculty in a nursing educational institution, a minimum BSc degree in nursing is required.

different clinical areas every few years, most respondents felt that acquiring specialized nursing skills through training and experience in one clinical area was more valuable than 'split nursing duties' - a term used by some respondents to describe a mixture of ward and ICU nursing, or moving between two or more clinical areas. Soraya, a 22 year old nurse who worked in one of the private hospitals explained:

Speciality working is better no? Than working in all other combination, speciality means we will come to know better. If other, all, it means it will be come to be like a mixture. This thing, that thing, we will not come to know in detail. Speciality means we can come to know regarding that case. We can handle individually. If others, means the cases will be together like cardio, nephro, neuro, everything will be together.

This view was supported by the Nursing Superintendent of a large multi-speciality private hospital in Bangalore who encouraged her students to consider specialization in a clinical area to avoid becoming what she termed as "a jack of all trades and master of none". The choice of speciality was often related to the perception of opportunities abroad, so that speciality areas such as obstetrics and gynaecology were not as popular as areas such as cardiology or psychiatric nursing that were considered to be much more 'in demand' overseas.

The choice of nursing speciality also revealed the gendered pathways through nursing in India. For example, male nurses were directed towards specialities such as psychiatric, emergency nursing and orthopaedic nursing which were seen as more 'suitable' for men. Although male nurses also undertake training in midwifery as part of both the GNM and BSc curriculum, none of the male nurses interviewed considered obstetrics and gynaecology to be an appropriate career path for male nurses due to cultural sensitivities around male-female interaction in India. Gender norms around the provision of care and the cultural notion of nursing as a profession better suited to women has resulted in a bias towards recruitment of female nurses in some hospitals. For example, the mission hospital I visited hired only female nurses, while the medical director of the private hospital told me though he did have some male nurses on his staff, he felt that female-provided care was preferred by the public as it is the 'norm' and consequently, the hospital mainly recruited female nurses.

The impact of wider gender norms within nursing has therefore also directed male nurses towards careers in nursing management and education. A number of nurse Principals and faculty in nursing colleges are male, as were many of the keynote speakers at nursing events attended during the course of this research. The relative ease of male nurses in climbing the career hierarchy into senior management both in hospitals and in nursing

education was raised by some female nurse leaders as an issue of ‘internal sexism’ in nursing.³⁹ Here, the patriarchal structure of Indian society was seen to be reflected in the internal politics of the profession in which male nurses become managers of predominantly female care provision.

Another key decision for female and male nurses is the choice of institutional setting in which to forge a career in nursing. Across the interview narratives, a career located predominantly in the public or private setting was depicted as ‘desirable’ or ‘undesirable’ for specific reasons. For example, as will be highlighted in the following sections, the often polarized views of the benefits of a working life as ‘public sector nurse’ or a ‘private sector nurse’ were particularly striking. To illustrate this divide between ‘public’ and ‘private’ hospital nursing, I use the narratives of Annie and Sarita working in the private and public sector respectively and compare their perspectives to those of other nurses across the data set.

Choice of institutional setting: the private sector

The private sector nurse (Annie, 32 years)

Annie comes from a small town in Kerala. Her mother is a housewife and her father, who owned a small business, died while she was still at school. Annie’s elder brother stopped his higher studies to look after the family and her younger brother soon joined him in continuing their father’s business. Annie recalled selecting nursing as most of her friends decided to enter the profession and it was easy to get a job. She was initially interested in pursuing a BSc nursing degree but did not pass the entrance exam and instead enrolled in a General Nursing and Midwifery (GNM) programme in a Christian mission hospital. She enjoyed her nurse training and became particularly interested in obstetrics and gynaecology where, during her practical training in the mission hospital, she was assigned to twenty delivery cases over a period of three months. After completing her training, Annie was required to stay with her hospital for a ‘bond period’ for two years during which time she elected to stay in the labour room. After her bond period had elapsed, Annie went to Hyderabad in the nearby state of Andhra Pradesh to join a multi-speciality mission hospital. When I asked her why she decided to leave Kerala, she explained that her ‘main motive’ was

³⁹ For example, the topic of gender inequalities in nursing careers was raised in some presentations at the state level nursing conference.

to learn English as she felt that the level of English in Kerala was low and that knowledge of English was important to work abroad or continue in further studies.

Annie spent a year at the hospital in Hyderabad and worked on the labour ward. It was during this time that she was advised by some of her doctor colleagues to think about another speciality - that of cardiology, as she would see more critical patients and the work would be more challenging. However, Annie was reluctant to change speciality and decided to continue in gynaecology. After a year, Annie heard of potential vacancies at a multi-speciality private hospital in Bangalore where a close friend of hers was working as a cardiology nurse. Although her friend encouraged her to join the heart unit at the hospital, Annie told her that she preferred to work in gynaecology and would submit her application there. Without her knowledge, however, her friend submitted two applications on her behalf, one to the gynaecology department and the other to the cardiology department. Annie was then called for an interview by the cardiology department for a vacancy which she successfully passed. As she did not have sufficient training in cardiology, she was told by the nurse superintendent that she would join as a staff nurse intern and be trained for one year, before taking an exam to progress to the position of staff nurse. Annie was initially undecided about accepting the post, but did not want to return home as she was afraid that people would think that she had been unsuccessful in her application. She recalled:

I thought that if I am telling that I have not decided to join, nobody will believe me (laughs) and that will be a shame for me. Then I thought 'let it be, I will join', like that I told. And I joined that hospital.

After successfully passing her nurse intern exam, she was promoted to staff nurse after one year and was also given the additional duty of 'shift in charge' where she was responsible for overseeing the shift rosters of the nurses on her ward. Annie worked in the heart hospital for two years. When one of the surgeons was asked to serve as Chairman of a new heart hospital, he invited a number of doctors and nurses to join him. Annie decided to follow along with a number of her nursing colleagues and worked in the heart hospital for six years. A new heart unit was then set up in a partner private hospital and Annie was again approached by the new administration and asked to be in charge of the Intensive Care Unit. She agreed and has been working in this capacity for the past year and a half.

Annie's story is fairly typically of the private nurses interviewed in this study in that she had worked in different private hospitals, unlike nurses from public hospitals who had less varied work histories and frequently worked in the same institution their entire career.

However, while Annie had been promoted to an in-charge position at a relatively young age, other private hospital nurses interviewed complained about a lack of career progression and incentives in the private sector. Like other GNM nurses, Annie acknowledged the limitations of a GNM qualification and that it was necessary to upgrade to a BSc. Annie's testimony also resonates with that of a number of other nurses across the sites in that personal and professional networks were important in her career decisions, particularly through learning about possible employment opportunities. I found that for most nurses, the use of 'networks' was key to designing a nursing career and therefore will be discussed later in this chapter in more detail.

Rival work cultures: private vs public nursing

Across the interview set, common perceptions emerged that were related to the choice of work setting in which to locate a nursing career. In particular, nurses gave vivid descriptions and opinions of working life in the public and private sector and often discursively defended the institutional context of their work, referring particularly to the types of patients who used the services and the quality of nursing care. Private hospital nurses in particular presented the private/public contexts as 'rival' work cultures, and typically described the public work environment in negative terms.

Annie's career thus far had taken place solely in the context of private hospitals and she was emphatic about staying in private sector nursing. Although Annie had not worked in a government hospital she told me that she had visited government hospitals during her nursing training. For her, government hospital nursing was characterized by lower levels of hygiene, limited equipment and a generally poor work environment. Annie was also very critical of government nurses whom she felt behaved in a rude manner with patients and created a negative image of the profession. In the following extract, Annie contrasts the low hygiene standards of a government hospital with the 'clean' and 'advanced' setting of her hospital.

- SJ: So, have you ever worked in a government hospital?*
Annie: No, no I haven't. Even I am not interested to be in a government set-up. I have seen government hospitals.
SJ: What are they like? What do you think about them?
Annie: Actually, usually that set up itself I don't like. Because we have learned in a private institution. We are using all the advanced technologies ... and even the cleanliness also. We are making our place neat always. And we are using all the stationary items and the toilets and we all are using all the tissue paper. Even for handwashing also we are using that

soap solutions. But if you go to a government hospital, you cannot see all those things. One hand towel will be there and many people are using the same things. And instead, one 'lifebuoy' (name of brand) soap will be there. More than that they will not use. Only lifebuoy soap they will use ... This one needle if they are using, again they will boil it and use for the other patient. And it is not sharp also. While giving, the pricking time itself, we can feel that. That sound will be there and like that it was. Even we were telling that 'how these people are working here. They are heartless people'! Like this they are behaving. And they are behaving very rudely to the patients. No value at all. No humanity at all.

Annie's concerns about government nursing were echoed by many of her colleagues who felt that a career in government hospitals would mean less exposure to modern medical and nursing techniques and equipment than that found in the private sector. When I asked Thomas, a 24 year old nurse from Kerala, whether he would be interested in working in a government hospital, he replied:

No, I am giving preference to private hospitals because hi-tech technology is there. Government hospital means nothing will be there. Nothing will be there. They will not provide proper materials, proper medicines also. How can we manage with those things?

The limited technology and equipment associated with government hospitals was not only seen as a disadvantage in terms of gaining new knowledge, but could affect nurses' 'job satisfaction' through limiting their ability to provide effective care to patients. For example, Meena, a 59 year old nurse whom I interviewed in a private mission hospital told me that she had been offered a government position but turned it down despite the possibility of a pension and other benefits:

Actually, I got a government seat but I didn't want to go to the government field because of their negligence, not giving patient care. Everything, everybody is money minded, so I don't want to go there, they will give retirement money and everything. So many facilities are there, everything they will give.

A number of private nurses interviewed had undergone their training in government hospitals and were therefore familiar with the environment and set-up of the public sector. Santosh, a 25 year old Keralite nurse working in the same hospital as Annie had undertaken his GNM qualification in a government hospital in Karnataka. Although Santosh recalled being able to get a lot of 'practical experience' during his hospital training, he told me how

the lack of facilities and high patient load in government hospitals led him to feel that he was unable to provide high standards of nursing care:

It is because of the facilities that they provide. If you are a nurse, you are bound to give the maximum care to the patient. But it is not only in your hands. It is also the facilities you have been provided in your position. If you want to carry out your duty, you need a lot of things. With bare hands you can't do it, you can't do anything. So, when you don't find anything to do for your work, you're helpless. That's what happens in the government job.

A few nurses also mentioned not wanting to become 'socialized' into the culture of government nursing, an environment which they felt produced nurses who were 'jaded' and often rude to patients. For example, Ashwani, a 23 year old nurse, contrasted the 'older' government nurses who 'talk rudely' to patients, with the staff working in her private hospital who were 'younger' and 'talk nicely'. The following is an extract from the interview.

- SJ: *So they are older? The nurses are older?*
Ashwani: *Hah! Older, older nurses are there. (Laughs)*
SJ: *There are no young -*
Ashwani: *There are no young nurses! Very roughly they are talking with patients. Here no, here old staff also here, but all the young staff are here. They are nicely talking with patients.*
SJ: *So do you want to work in a government hospital or do you want to work in private?*
Ashwani: *Private hospitals only.*

Bhavna, a nurse working in the private teaching hospital, pointed out that in addition to the perceived rudeness of the nursing staff, patients were also 'badly behaved' and that working in this kind of environment did not interest her at all. She told me "*The way they behave to the patients. And the way the patients behave, it is just horrible*". For many nurses working in private hospital settings, a preference for private hospital employment was most often related to the ability to work in a more exclusive, hi-tech environment that was considered to be more service-oriented and client-friendly than government facilities, particularly as patients were paying for high quality care.

This image of the 'high-tech' private hospital, however, mainly applies to those hospitals catering to the upper middle-class and rich. During my fieldwork, I observed a wide variety in the standards of private hospitals, where one private teaching hospital visited was very basic compared to a nearby modern private hospital which clearly catered to a wealthier clientele. In this respect, I was privately told by one of the nurses that it resembled more a

‘government hospital’ than a private one as it was heavily subsidized and mainly treated low income patients. Despite this, nurses working in this hospital shared similarly negative views of government hospitals to their colleagues in the ‘up market’ hospital next door. For example, Kaveri, a 60 year old nurse responded to my question about the differences between government nursing and private nursing by highlighting the difference in patient care, which she said was “*very good here only*” and that there was “*no patient care at all*” in the government set-up.

For many nurses, the distinction of a being a ‘private nurse’ was very important and a key part of their personal biography. In their narratives, private nurses frequently presented their identity as that of a ‘private nurse’ and disassociated themselves completely from government nurses as this was perceived as a threat to their professional image.

Accounts of career incentives in the private sector

Although nurses praised the work environment of private hospitals with reference to the levels of hygiene, medical care and equipment, many felt that a career in the private sector was insecure and that there were fewer financial incentives. Employment insecurity was most often related to the concern that one mistake would lead to instant dismissal and that private nurses had fewer ‘rights’ than their government hospital sisters. For example, Miriam, a nurse working in a private mission hospital told me that although she much preferred the work context of a private hospital, the pay was not adequate and there was less job security:

In private hospitals we don’t have any guarantee for the job. Anytime we can have the punishment and we don’t have much laws to support us. And we won’t get all our allowances like in government.

Most of the critique levelled at government hospitals was focused more on the work environment rather than the career benefits available to government nurses. In this respect, the majority of the private nurses interviewed, including Annie, acknowledged that the biggest incentive to work in government hospitals was the ‘job security’. Annie explained:

See, people will be attracted (to the government sector) only because of the job security. And they are getting the pension and all, once after their retirement period. Only because of that people are more attracted.

Santosh also explained how a 'government job' is an attractive option to nurses because of the benefits provided, particularly higher salaries, a pension, education and health allowances for dependants and other benefits. He contrasted these with the private sector, where the work environment is less 'secure':

It's not for constant work satisfaction and all, it's er like you have a higher security with your life settlement when it's the government job. But with the private sector you can never find. Anytime you may be out, any time. It's not for job security.

Similarly, Lizzy told me that she had previously applied for a government job but had missed the required grades in the entrance exam by 1%. In explaining why she had tried to enter a government hospital she explained:

Yeah well government sector means that you will get a good opportunity and you will have the good life security there. And compared to the salary based (in the private hospital), salary and everything is higher in the government sector only.

It is difficult to ascertain the salary scale in private hospitals as these vary greatly and are fixed by the institutions themselves. However, private sector salaries are generally lower than in government hospitals. Some nurses mentioned that their starting salary as a nurse intern in a private hospital was around 2,500 Rs (£37) per month whereas others reported receiving 5,000 - 7,000 rupees (approximately £70 - £100) when they first started as a newly qualified nurse. Dr Tandekar, one of the hospital administrators with whom I spoke about nurse salary scales told me that the pay structure at the hospital was designed for those nurses who "will stay with us for a long time". Dr Tandekar explained that the hospital had a high turnover of young nurses, most of whom were leaving to seek employment abroad. Therefore, the administration did not pay recent graduates as much as older nurses as they had much less experience and because they were not sure if they were going to leave the hospital once they had acquired the two year's experience necessary for finding a nursing job abroad. A demonstration of 'commitment' was therefore also incorporated into the career structure for nurses at the hospital along with age and experience. As Dr Tandekar explained:

So, what we do is at the initial time when they are training, we put them as staff nurse interns and then they do the test. Once they have got adequate scores they become staff nurses. Then a few years later, you will have an idea of those who will be staying with you and those who will not be staying with you. Those who are staying with us over a period of time, they will become staff nurse managers and higher. From that point out, the pay is quite high compared with other hospitals.

In this hospital and other private hospitals included in the study, nurses received yearly pay increments which meant that older, more experienced nurses received significantly more than their younger colleagues. However, private nurses still compared their salary scales with those of their friends and acquaintances working as government nurses. For example, Kaveri, a 60 year old nurse working in the private teaching hospital told me that, unlike in the government sector, she had limited possibilities for career advancement despite a long period of service in the hospital. Although Kaveri had received a yearly increment, she did not receive corresponding changes in grade despite being given managerial responsibilities.

Similarly, Vandana, who is 58 years old and works in the same hospital, told me that through she was receiving 17,000 Rs (£250) a month, her friends were getting 30,000 Rs (£450) per month in government hospitals. Vandana also complained that the chances for promotion were fewer: *“After ten years, you become head nurse, after fifteen years, nursing superintendent. Here nothing”*. When I asked her if she would prefer to work in a government job over her current employment in a private hospital, she replied *“government job”* with no hesitation. There was also the perception of a more linear career progression in the public sector compared with private hospital employment. Vandana explained:

Promotion here is not given. Here, I have been 16 years, staff nurse, ward-in-charge. Ward-in-charge they are telling, but grade is not given.

When I asked Vandana to describe the process of career advancement in the government sector, she replied that there would be both pay increments and increases in nursing grade:

Seniority means increment also, but then promotion also they will give, grade also they will give.

Another frequent complaint was that access to further education was difficult while working in the private sector as the costs of further study were typically not borne by private institutions. Some nurses in the private hospitals told me that they would like to undertake a post-basic certificate to upgrade to a BSc qualification but could not afford the time off or the costs of the programme. Manjula, a 24 year old GNM nurse working in a private teaching hospital recounted:

In government training, scholarship is available, like they provide stipend, it is government training. Since I was doing in government training, I received 1,000 a stipend, but now we do not receive, for government staff they can pursue further

training with salary for free. We now as we are in private, not in government, we have to pay money.

Consequently, while some private nurses like Annie and Meena demonstrated no desire at all to construct a career in the public sector, for others, the perceived benefits of a career in the public sector through the incentives of better salaries, the potential for further study and opportunities for career progression were a powerful motivator to seeking employment in this institutional context.

Choice of institutional setting: the public sector

The public sector nurse (Sarita, 38 years)

Sarita was born in Mysore, Karnataka, and came to Bangalore as a child due to her mother's job as a staff nurse in a government hospital. Sarita was initially reluctant to enter nursing as her mother worked long hours and frequent night shifts and, as her mother was employed by the state government, she was transferred regularly along with her family. After finishing school, Sarita wanted to study computer science at university but was overruled by her mother who insisted that she join nursing. As Sarita had the required marks in science subjects, she joined a BSc nursing programme in a government college of nursing. In her interview, she recounted remaining a 'reluctant recruit' to nursing until well into her third year and it was only when she began her hospital internships that she began to really enjoy nursing and felt that "*it was a great thing to be a nurse*".

After graduating, Sarita applied for a job at a reputed central government hospital in Bangalore and was called for an interview. Her preference was to work in a central government hospital rather than as a state government employee as nurses would not be transferred to different places every three years as was the case with her mother. While waiting to see if her interview had been successful, Sarita decided to join a friend of hers who was working in a private mission hospital in Bangalore. Sarita was posted to the ICU and worked there for only one month before she was informed that she had secured a place at the government hospital.

Sarita has worked in the central government institution for fifteen years and has recently completed her MSc in nursing. During this time she has been posted to various wards around the hospital, including the ICU, Casualty and the general adult wards. Her MSc took two years to complete and was supported by the institution during which time she also worked

in a reduced capacity as a staff nurse.⁴⁰ She is currently based in the neuro-surgical ICU of the hospital.

Accounts of career incentives in the public sector

Like other nurses interviewed, both in the private and public sector, Sarita highlighted 'job security' as the main reason why a career in government service is desirable and compared this with working in private hospitals.

The thing is, this is a national institute and the central government rules are applicable and in India, people prefer to be in a government job because of the job security. But in the private sector you don't have job security. You are governed by certain rules and people can make you work according to their whims and fancies. (In the government sector), you are governed by certain rules and you can demand things you want as per the rules. So people prefer to work in government institutions.

The 'lifetime' security of a career in government service was also important to nurses particularly as they would receive a pension, health insurance as well as housing and other benefits. Interestingly, a few nurses thought that the private sector salaries were higher than those of public sector nurses, but still preferred to stay in government service as it was more secure and they could grow professionally. Parvati, a 34 year old nurse who had worked for the government hospital for 11 years felt that private nurses were paid higher salaries but were 'thrown around' like a 'football' in that they had less security and autonomy over their careers:

In the government sector it is a very secure life. So that's what I wanted. Because outside you will be football, you will be thrown from this institution to that institution.

Parvati obtained permission from the hospital management to undertake her MSc in nursing in 2006 and received a salary during the two years of the course as well as study leave. In light of this, she told me that working in her hospital gave her a feeling of security:

It is a very secure life and you don't have to worry about the other things, your personal life and professional life. I think it is fantastic in (name of hospital). So you can grow professionally, you can grow here.

⁴⁰ During her study period, Sarita did not receive a full salary as there was a small deduction for the course.

For nurses across government and private sites, continued education in nursing was seen as very important, being both key to career progression and to ensuring a high standard of nursing care. Nurses in the government sector are more able to pursue these opportunities as part of their professional careers than private nurses as they are supported by government scholarships or bursaries that cover fees and related expenses.⁴¹ However, entry into these programmes is competitive and candidates must first satisfy entry requirements. For example, in one government site where I conducted my interviews, prospective MSc candidates must have sufficient years of experience within the hospital before being recommended to undertake further studies. This is followed by a written exam and interview. The candidate is also reviewed against other criteria such as work evaluations and recommendations by doctors and senior nursing staff. Consequently, not all nurses who desire to continue in further education are permitted to do so. For example, Aakesh, a male nurse whom I interviewed, told me that he had applied to do an MSc twice but was turned down for reasons that he related to staff scarcity and 'internal politics'.

In addition to concerns about job security, most of the government nurses interviewed generally portrayed the culture of the private sector as being undesirable due to a perceived lack of independence and responsibility in making decisions and an unsympathetic administration. In this working environment, nurses could lose their jobs over a 'small mistake.' The following is an extract of my interview with Sonya who had worked for 20 years in government hospitals.

SJ: Why did working in a private hospital not interest you?

Sonya: Because, see that is because I never had the necessity to apply to the private sector. Because of good marks and all, immediately I used to get the job. And second thing, if anyone asks me also, I would say, see government is always government, till our last breath, we have the bread. In the private sector, that is not there no? And the moment some mistake is found on you, immediately you are thrown out. Whereas here, there are of course, definitely disciplinary actions and everything. But still, job security is there. That's how I advise to my juniors.

Just as private nurses accounted for their decision to work in the private sector through reference to the undesirable aspects of government hospitals, some government nurses also defended the institutional context of their work in their narratives. For example, these

⁴¹ A few large private medical foundations do sponsor further education for nurses affiliated with their hospitals.

respondents were keen to associate themselves with a 'service to the poor' that they contrasted with the 'money minded' nature of the private sector. Lakshmi, a 52 year old government nurse told me:

Private sector hospitals are only money minded. They are all money minded. Even they will give less pay to the staff, even their trained staff ...

Another of her colleagues, Grace, had worked in a private hospital at the beginning of her career for six months before joining the central government hospital, where she had been working for the past 11 years. When I asked her whether she would like to remain in this hospital or had plans at some point to rejoin the private sector, she told me that she was not interested in making such a move:

No, I'd like to work in (name of current hospital) only because many poor people, irrespective of their status, they will come here. Many poor people will come. I feel like to serve the poor people better than the rich.

Government nurses did however acknowledge that some of the private hospitals in Bangalore were very competent in terms of the treatment and care that they provided and that the levels of hygiene and sanitation were frequently higher in the private sector. For example, during a tour of one public hospital that I visited, my nurse guide pointed to a line of patients' relatives sitting on the floor in one of the corridors drinking and eating:

See that! See the environment we have to work in? All these people around. Our hospital is dirty, unlike private hospitals.

At the government sites where I conducted my interviews, I found that nurses were generally older, where this may reflect a lower turnover among staff at these institutions. I was also informed that it was difficult to enter government service as there were long waiting lists and relatively few job openings. Consequently, given the value associated with the public sector in terms of security 'for life', government nurses appeared, on the whole, less keen to migrate for overseas employment than their colleagues working in private hospitals. As Grace explained:

Many are saying that when they get a government job or they are secure with their job, they feel like staying here (India) only.

There were however, some exceptions to this. As will be discussed in the next section, a few government nurses shared similar views to their colleagues working in the private sector, namely that migration offers nurses the possibility of increasing their earnings and moving up through the nursing hierarchy.

Migration as a career strategy

Perhaps the most radical decision nurses can make to further their careers is to migrate. Analysis of the interviews indicates that the decision to migrate is strongly rooted in the desire to 'earn more' and 'learn more'. Most nurses complained that nurses in India are not well paid and that this was a major incentive to work abroad. For example, Thomas pointed out:

Nowadays nursing employment is seen as a good job. But the basic salary for nurses is very less, that is why all the nurses want to go abroad. So, salary, when comparing to other salaries that we are getting in India, that is more than double.

Thomas told me that he would like to work abroad for between five to ten years where upon his return to India, he could expect to receive a much higher salary as an 'experienced nurse'. Similarly, Rita and Shalini, two 29 year old nurses from Kerala felt that nurse migrants are given more status upon their return and find it easier to obtain a better paid job. They presented the decision to move abroad as a way to acquire a significant return on the investment in nursing training by their families, an investment that they feel has less of a financial return if they were to stay in India:

Rita: See, if you finish your BSc also, hardly you will get 4.5 (4,500Rs). So very hardly they have to do the studies and they are spending much money, lakhs⁴² and lakhs, and then the hostel, books everything. And then after training, for the food, everything they are spending. And I think that all the people are coming from my place, our place, Kerala. They are not like 'big shots.' See, all are working hard. And they are sending money to their daughter or son for studies. And at the end, they are getting 4.5. What is the point of doing that?

Shalini: Exactly, so they are going abroad.

Rita: They get more experience. So the girls would like to go to abroad. They'll get more money, more experience, once they come back to India, more value. 'Oh! She has been abroad! OK! OK! You are appointed.'

⁴² 1 lakh is 100,000 Rs.

SJ: *I see. And then they can get much better salaries?*
Both: *Yes.*

As discussed in the previous chapter, a few respondents also mentioned their desire to 'learn about new cultures' and 'gain knowledge' through working abroad. The desire to 'gain knowledge' was used both in the sense of improving nursing knowledge and skills, as well as learning more about other societies.

Some of the accounts demonstrated an idealized vision of working abroad, where nurses believed that they would operate in 'high-tech' environments with 'high-tech' equipment and 'high-tech' methods. Ashwariya, a 24 year old nurse, whom I interviewed after she had just returned from an interview for a nursing vacancy in Saudi Arabia, is one such nurse. Attracted by the prospects of working in 'high-tech' hospitals, she told me:

Abroad we will get more salaries and high tech hospitals, machines, everything is very high tech. And we can see all people, cultures, we can learn, that's why.

Professor Nande, a return migrant and the principal of a nursing college I visited, felt that his time abroad in the Middle East had been extremely valuable in terms of the knowledge and experience that he could 'bring back' to India:

And also you see, I have been to Oman, I have been to Saudi Arabia, I got rich experience there, I am bring back to my country. See if I am only in India, I don't think I will be able to come to this level.

A range of countries were mentioned as desirable migratory destinations including Australia, Canada, Ireland, Oman, the United Kingdom and the United States of America. One or two nurses mentioned not wanting to work in countries such as Saudi Arabia, because they could not go to church or walk outside unaccompanied.

Most of those interested in overseas employment told me that they planned to return to India after a few years. Consequently, migration was largely viewed as a short-term career strategy rather a longer term life strategy related to 'settling abroad'. Family reasons were usually given as the main reason for this. The following is an extract of my interview with Soraya, a 22 year old nurse working in a private hospital who told me that though she would like to work abroad for a few years, she intended to return to India:

SJ: *So you would like to come back?*
Soraya: *Yeah, I'll come back. No settling and all. I'll be back.*

SJ: *Why don't you want to settle there?*
Soraya: *No, everyone is here and how can we settle there? It will really be very difficult for us. Going and coming back we'll miss so much and getting settled over there and leaving whole of the family it is really difficult.*

Only two nurses, both in their mid twenties and from Kerala, mentioned wanting to settle overseas and highlighted Australia, Canada, the United Kingdom and the United States of America as possible destinations. One of them told me that these countries were preferable because nurses were able to obtain citizenship, unlike the Gulf countries where foreign workers are not awarded a permanent right to settle.

'Localites vs out of towners': profiles of 'would be' migrants

For many nurses, taking up a job overseas would be their first time to leave India. Consequently, a number of the study respondents were not prepared to take this step and preferred to remain in the country. In some narratives, India's needs were presented as the reason to stay and 'serve' within the country rather than migrate overseas, and consequently some respondents used a more nationalistic discourse to explain their reasons for staying in India. For example, Sarita told me:

My idea is that I have taken so much from my land, I should serve back in my way. This land has nurtured me for twenty two years ... so I need to give back to society and to my people. So, I have no ideas to go abroad.

Similarly, Lakshmi asserted that she had never been interested in leaving India, saying "*I wanted to be with my family. I want to serve my India. I will not go abroad*". As the interviews progressed, I began to notice the emergence of distinct profiles between those who wanted to go abroad and those who did not. Nurses who typically had plans to migrate were on the whole younger, worked in the private sector and were 'out of towners', the majority of whom were from Kerala. This contrasted with the testimonies of 'localite' nurses from Karnataka who, for the most part, showed little interest in migration. The relative reluctance of government nurses to migrate as opposed to those in the private sector may be related to higher wage structures and benefits in the government sector that make migrating overseas less of a career incentive. However, a few government nurses did mention being interested in working abroad despite the comforts of life in the public sector. For example, Veena, a 33 year old nurse working in a central government hospital told me that she would like to

migrate to the United States with her husband, who is an engineer, so that they can earn more money and “*come up in life*”. Aakesh, who worked in the same hospital, also told me that he would like to go overseas so as to improve his knowledge in nursing. Other exceptions included a few female nurses from Kerala who told me that though they were attracted to the idea of working abroad, they did not feel this was possible and mainly related this to ‘family reasons’ which typically included not wanting to leave their children and not having the support of their husbands.

Rather than being an ‘individual’ and incentive driven choice, for many of the respondents, the decision to migrate was influenced by contextual considerations, particularly, family circumstances. Although the prospects of increased skills and higher pay function as important career incentives to migrate abroad, these incentives alone do not account for why some nurses felt more able to take up these opportunities, while others were not. Rather than taking place as an individual process, the decision to migrate is often ‘communal’ and influenced by the existence of overseas community networks, as well as family and spousal support. These features were particularly evident in the narratives of nurses from Kerala.

On the whole, Keralites were portrayed by members of their community and by the ‘localite’ nurses as being culturally different to nurses coming from other states in the South. The long history of migration from Kerala compared with those of other Indian states has given rise to the cultural perception of Keralites as internationally ‘mobile’. For example, during my fieldwork, I heard a few variations of a joke told to me by both Keralites and non-Keralites: “*When man first arrived on the moon, a Keralite offered him a cup of tea*”. Rather than being malicious in nature, this joke was told in a way that light-heartedly poked fun at the perception shared by many Indians that Keralites are worldly, ambitious and enterprising. Whereas many people from Kerala have large networks of overseas relatives and friends, those from other Southern states do not. For example, Aarushi, a young nurse from a rural area in Karnataka, told me that for her family, her move to Bangalore was akin to moving abroad:

No I am not interested to move abroad, my family would not permit me to move abroad. Sending me to Bangalore itself is a big thing, sending me abroad is far from happening.

The above quote captures a sentiment that was frequently echoed by the ‘localite’ nurses interviewed - that they were on the whole more settled in Bangalore and where many had families and a social network rooted within the State. The Keralite ‘out of towners’ on the

other hand, had already migrated to Bangalore which for many of them was a stepping stone to employment abroad. This is particularly because Bangalore is home to a number of large hospitals (those of 1,000-beds and above), where employment experience at hospitals with high bed strength is a pre-requisite for successful overseas nursing applications. For these nurses, leaving Bangalore for employment overseas therefore represented another step along the migratory chain.

Sister Eileen, a return migrant nurse from Kerala and the Nursing Superintendent of a private mission hospital gave a particularly vivid account of the differences between 'Keralites' and 'localites', saying:

There is a cultural difference you know, like Kerala people from the beginning, their educational background you know, 100% literacy and all that. Their orientation is different. Culturally they are brought up in such a way, they are the fighters you know. They want to try. They are daring. People want to go anywhere, and their livelihood, make money and better their prospects. But people from Karnataka and Tamil Nadu, their culture is different. They used to be, now they have started coming from Tamil Nadu to Bangalore and to (name of hospital) and it is like going to America for them. So that's the cultural difference is there. They are not daring that much because they have not got that from their families. Now they are coming up a little bit and trying to go out and all. But coming from Tamil Nadu to Karnataka, they think it is really far and things. It is a cultural difference. In India, it varies from state to state and each state has its own culture. So, Keralites are very different from all other states, especially in their education and in going, you know. They are more daring because that is in their genes ...

Some of the 'localite' nurses felt that nurses from Kerala were generally 'money minded' compared to nurses from Karnataka. For example, Lakshmi stated:

Keralites from the beginning are like that, what I understood. I am not blaming anybody. What I have understood is that they are very money minded. Yes, money minded. But we are not like that. That is my opinion. After 30 years of service, that is my opinion.

For some, the trend towards external migration as a 'rite of passage' for Keralite nurses was viewed as an unwelcome source of 'pressure'. Suzanne, a nursing tutor from Kerala whom I interviewed at a nursing college had worked overseas in Oman, and told me that she had no plans to leave India again. Suzanne's friends did not understand her decision to work in India and kept encouraging her to move abroad:

The thing is, you know, the problem is, back in Kerala you find every house in Kerala there'll be at least one person in the Gulf or US, or UK. So they always get fascinated

with it, you know, that is the problem ... Most of my friends ask me like how, why, I mean, how do you feel like staying back in India? Why don't you come abroad? And, you know, they think it is something below their standards to stay back in India. They have to go abroad. Once they complete nursing, they will be determined to go abroad. They think like that.

An important underlying factor that may push nurses particularly from Kerala towards seeking employment abroad is that through a foreign salary they are able to save significant amounts of money for a 'dowry'. As highlighted earlier in the previous chapter, marriage is a costly affair in India and families typically spend many times their annual income in paying for wedding celebrations and gifts for the groom and his household (Anderson 2007). Although the giving of dowry is found throughout India, there are variations in dowry practices across the country (Dalmia 2004). It is difficult to compare dowry payments between Kerala and Karnataka as comprehensive data on dowry practice is limited. However, participants in this study frequently referred to the difference in dowry practices between communities in Karnataka and those in Kerala, stating that in Kerala, these typically include large amounts of cash, jewellery and other goods and are disproportionately higher than surrounding Indian states.⁴³ Although a nursing qualification is increasingly perceived as advantageous on the marriage market and may reduce the financial burden of dowry payments, many Keralite nurses still continue to save up for a dowry so as to ensure the possibility of a 'good marriage', i.e. where dowry functions as a means to maintain social status or, by meeting the dowry expectations of a groom from a higher income bracket, offering the opportunity for social mobility (Anderson 2007).

Constructing nursing careers: communal decisions and the importance of 'networks'

Despite the general trend towards outwards nurse migration from Kerala, not all Keralite nurses were able to make autonomous decisions to work abroad. Here, a key consideration shared by both 'localite' and 'Keralite' nurses in their decision-making around careers, including migration, is the attitude and support of their families. The decision to migrate was often viewed as a 'communal decision' made in the context of family support and approval. For example, one of the frequently mentioned reasons why nurses did not want to

⁴³ Dowry is not however, practiced uniformly across Kerala. A recent study on dowry practices describes the rejection of dowry among communities in the north of the state (Kodoth 2008).

migrate is because their parents/husband/children did not want them to. For example, Ashwariya told me about the Kannadiga girls with whom she stayed in the nursing hostel:

They won't go. Most of them don't want to go because their parents won't allow them to go ... Yeah, they are thinking something wrong like that for going abroad. It is very far from India, like that.

Having the support of a husband is instrumental to the decision-making process around migration for female nurses. Laila, a 31 year old nurse from Kerala, told me that she had worked abroad in Malaysia before returning to India to get married. After her marriage, Laila did not return as her husband “*was not that much interested*” in migrating overseas. A few nurses mentioned that they would need their husbands’ ‘agreement’ in order to make such a decision. For example, I asked Bhavna, a 29 year old nurse from Karnataka working in the private teaching hospital whether she had considered working abroad. She replied that this decision was dependent on the approval of her husband and family:

In the future, my family, my husband would have to agree for that no? If he gives agreement I will try for somewhere.

Similarly, Rita, who was working in a private outpatient clinic, told me that though she was keen to work abroad, her husband was not willing to leave Bangalore. Interestingly, Rita informed me that her husband is also a nurse and a ‘localite’, whereas she is from Kerala. Later in the interview, Rita laughed: “*He told me very frankly ‘If you want to go, go! Forget about me.’*”

Concerns about leaving children in the care of others were also frequently highlighted by female nurses as a barrier to working abroad. Consequently, for many young nurses, migration was an experience to capitalize upon *before* marriage and family life. Parvati, a government nurse from Karnataka, told me in response to my question about whether she had considered going abroad:

Yeah, that was before marriage obviously. But now after having my child, maybe even after my marriage also, I even thought about going abroad. But after the delivery, then I just stopped thinking about going abroad.

Similarly, Annie, with whom I had a long discussion about migration, told me that though she had briefly considered going abroad like her friends, her attitude changed once she had children:

No, I am not interested to go abroad now. I want to concentrate on my family, I don't want to leave my son like that. Even my second son is very small, only six months of age. But my first son he is four years old. In this age if I am leaving him like that, I will spoil his mind also.

Malika told me that she would only consider migrating if it was with her family as she didn't want to leave her baby with relatives. In addition, Malika felt that migration would be an opportunity to provide her children with a better education than that available in India and was another reason why migrating with the family was important:

Yah with the family only I would prefer to go. Because if we get settled there, there are the children's education and all, it will be much better than here.

Other female nurses, however, did leave their children with husbands and relatives while they worked overseas and saw their children during school holidays or during leave periods. For these nurses the separation was particularly difficult and consequently, most returned to India after a few years.

Gender norms are particularly evident in decision-making processes for women and girls in India. For example, before marriage, a young woman's family and kin networks are instrumental in making decisions around key areas of life such as education, employment and marriage. After marriage, decisions are frequently made in consultation with husbands and 'in-laws'. In the following interview extract, Savitri recounts how her husband was initially opposed to the idea of her re-entering hospital nursing and described how this was only made possible by the intervention of Rear Admiral Ganapathy, a former medical colleague with whom Savitri worked as a military nurse before her marriage, who was able to convince Savitri's husband as to the possibility of a dual role as a working wife/mother.

'Where are you working now? Where are you posted'? He (Rear Admiral Ganapathy) asked me. I said 'No Sir, I left my studies and I got married and had two kids. My husband is a Commander in the Indian Navy, so I am having just a family life Sir, nothing else.' 'No, you are wasting your time. I think it is better that you get back to your job', he said. I said 'I have two children' and he said 'So what! All those working people, do they not have children? That is not correct' ... and he gave me an application form and said 'I would like to meet your husband also'. Then when my husband came back from after three or four days of sailing, I took him there and he was given a real brain washing saying 'You are wasting her talent being a great nurse, an OT nurse and I think you should put her back in the hospital'. My husband replied 'But the children, and I frequently go sailing, so what will we do'? He (Rear Admiral Ganapathy) replied 'No, no, you will, we are all from a defence background

and we always have attached servants quarters. We have maids and they are capable of taking care of the children ... there won't be any problem and she will get adjusted'. So, finally I joined the service in Bombay hospital.

Female nurses in the study often referred to extended family members, including their in-laws, when discussing decisions around where to live and work. Sonya was one such nurse. Sonya's family was from Tamil Nadu but, as her father worked for the Indian railways, she was brought up in Andhra Pradesh. After working for a few years as a hospital nurse and then as a nursing teacher in a government hospital in Chennai,⁴⁴ her parents arranged her marriage with a young man who was working in a mining company and stationed near Bangalore. As Sonya had a 'government job', her husband considered a transfer to the company's office in Chennai. However, his family who lived in Bangalore insisted that Sonya give up her position and move to Bangalore instead:

- Sonya: *After the marriage, my husband said 'She is in a government job. Let her continue. I will get a transfer to Chennai...So, I'll get a transfer to Chennai to the office side' he said. But my mother-in-law was er, even today, my mother-in-law is the ruling commander in our family! In our family, she is the commander. So, she said 'No, once she is married, she should come to our side not we go to her side'!*
- SJ: *And our side means where? Tamil Nadu?*
- Sonya: *We are all from Tamil Nadu! But my in-laws are settled here in Bangalore. So, she said that she should come here not my son going there. So, ultimately, I had to resign that job.*

Although male nurses appeared to be less constrained by gender norms that act upon women's ability to demonstrate autonomous career decisions, male nurses also made key life decisions in consultation with their families. For example, young, unmarried male nurses looked to their parents for advice around their careers, many of whom had joined nursing upon the recommendation of their parents. Out of the seven male nurses interviewed in this study, six had joined nursing following the encouragement of their parents.⁴⁵ One male nurse from Karnataka told me that he was not considering migrating overseas as his parents were not in favour of this, indicating that male nurses may also seek the approval and support of their families with regard to migration. In addition, marriage in India is a communal affair

⁴⁴ In 1996, the state government of Tamil Nadu renamed the city of Madras as Chennai.

⁴⁵ The male nurse who did not have the support of his family explained that he had initially undertaken a degree in Commerce and was working in a company before he decided to leave this job and enter nursing training. His family were concerned that his occupational switch was risky and that training would be expensive. He was encouraged to pursue nursing by a female cousin who was working as a nurse in the UK.

where marriages are typically arranged by family and community networks for both men and women and is frequently endogamous.

The function of networks

Across the sites, nurses described themselves as part of a nursing cohort and frequently mentioned their peers as the 'batch' with whom they studied. Networks of 'batch-mates' serve as an important source of advice and encouragement for nurses and are a key mechanism through which information is relayed about employment opportunities within India and abroad. In learning about available employment opportunities, nurses typically consulted vacancies in the newspapers as well as their community, family and batch-mate networks.

The interview narratives demonstrated the importance of two types of networks in constructing a career in nursing - 'social' and 'professional'. 'Social networks' include family, community and batch-mates and are mainly horizontal in that they function as a 'news service' about available opportunities in nursing, including possible employment in Bangalore as well as working overseas. A number of nurses across age groups told me about their batch-mates working abroad, with whom many continued to keep in touch. Karthik, a male nurse from Kerala, told me that he was very keen to join his friends who had already migrated for jobs overseas. He described receiving regular reports from them by email and by phone about working life abroad, including encouragement to 'join them'. He told me:

Actually my goal is to go abroad. Means Australia or US. Because my friends are working there. They are telling it is a nice place, you come here, please come immediately.

Many of the younger respondents, particularly those in their 20s, described how they had submitted their applications to particular hospitals in Bangalore because their friends were working there. The desire to work alongside friends indicated that rather than being a site of 'competitiveness', social networks were supportive and cohesive. As highlighted in the methodology chapter, the importance of 'friendships' was also apparent during the data collection where some of the younger nurses, particularly in the first two interview sites (the private hospital and private teaching hospital), asked me if they could be interviewed with

their 'friend', where this was often someone that the nurse had known since childhood or was their 'batch-mate' during their nursing training.⁴⁶

In his interview, Santosh emphasized the extent of networks among the Keralite nursing community. He explained:

It's a lot of networks because as you know, basically, in this field it's like 95% Kerala people and it's a lot of network between the staff, the students and so, so many people from the same towns. There is a lot of networking, so somehow you come to know which hospital is having vacancies. Rather than coming to know from ads and all, it's from the network itself.

'Professional networks' include other nurses and medical professionals who work at the hospitals. These are mainly vertical in that they assist nurses in learning about employment opportunities, writing reference letters and providing recommendations for vacancy positions. Some nurses described how some doctors with whom they had good interpersonal relationships within one hospital and who had subsequently moved on to another, also continued to keep them informed of vacancies. In the case of some of the nurses interviewed, these professional relationships had led to them being hired directly. As was the case with Annie, a number of the nurses at the private hospital had followed their medical director from another hospital in Bangalore to staff this new facility. Nurses also reported being frequently advised by doctors about potential career paths, such as choosing speciality areas within nursing or the potential for migrating abroad. Some nurses who described being assisted by doctors highlighted how they also came from the same 'community', e.g. from the same town or state. Consequently, it is likely that the reach of these community ties within professional networks in hospitals and teaching institutions is also extensive.

Summary

Although the concept of 'career' is helpful as a framework within which to examine employment choices and work history, the interview narratives revealed that family networks, in particular, reproduced and reinforced culturally accepted behaviour that make it inappropriate to conceptualize career decisions as being 'individualistic' in nature. As we have discussed earlier in this thesis, Indian society is characterized by the importance of collective identity over individual identity, where an individual has traditionally been located

⁴⁶ See Appendix 10 for photographs of female and male nurse 'batch-mates'.

within social groupings, particularly those of village community, religion or caste and the joint family system (Beteille 1992). It is therefore within the context of these social groups that key life decisions are typically undertaken by both men and women in India. Consequently, 'autonomous' decision-making is relatively rare in this cultural setting as making choices almost invariably involves the consultation and moreover, approval of kin networks. In their narratives, nurses frequently described themselves as part of larger social groupings that included family and community. In addition, as evidenced by the patriotic discourse employed by some nurses, a further collective identity is that given to being part of the Indian nation.

Another striking feature that emerged through the examination of nurses' careers in the study setting was the formation of a distinct professional identity along institutional lines—particularly that related to working in a public or private hospital setting. Being a 'private' or 'government' nurse functioned as a central theme in the recounting of a nurses' personal biography and was important to nurses' understandings of their working lives as nurses. In the following chapter, we shall explore nurses' working lives further so as to discuss the ways in which nurses constitute a sense of professional identity through nursing work and in the management of professional boundaries within hospital settings.

Chapter 5

Nurses at work: managing professional relationships

An opportunity to observe nurses 'at work' came during the first week of conducting interviews in Site 1, a private cardio-thoracic hospital, where the Medical Director of the hospital (also the chief cardiac surgeon) invited me to observe a heart bypass operation. This experience enabled me to access the 'private world' of the Operating Theatre (OT) and also served as a starting point from which to examine the interaction between doctors and nurses in the study setting. The following extract is taken from my field notes describing the event:

Unlike the televised depictions of casualty OTs, which typically involve lots of drama, blood and shouting, I was struck by the surprisingly pleasant ambience that greeted me when I joined a small group of observers mid-way through the operation. Soothing classical music interspersed with a few 80s soft rock ballads were playing from the surgeon's ipod set up in the corner of the OT and which at times generated some soft humming from the surgeons and anaesthetist. In addition, between the 'professional talk' of the surgeons about the procedure that included explaining steps of the operation to those observing and requests for equipment and updates, there was also some chatter. This chatter included a few inside jokes about the chief surgeon told by a visiting consultant and other doctors present, some general talk about former patients and procedures, and (to my embarrassment) a few joking comments about my research. This was sparked by Santosh's arrival in the OT to observe the operation. I had interviewed Santosh a day earlier, and after greeting me, he began explaining in whispers 'who was who' and 'what was going on'. One of the junior doctors observing the operation turned to me and jokingly asked if what Santosh had said during his interview was interesting. I was too surprised to answer and fortunately Santosh laughed and replied "it's confidential!" Another junior doctor then told his colleague "you should have found another way to ask. Obviously she won't tell you if you ask like that" thereby provoking a general round of laughter.

The Operating Theatre has been described as the backstage area of hospitals in that it is a highly controlled space, governed by explicit rules of hygiene and conduct, and 'off limits' to the uninvited (Tanner and Timmons 2000; Fox 1997). In their observations of Operating Theatres in different NHS Trusts, Tanner and Timmons point out that the behaviour in theatre is markedly different from that found in other areas of the hospital, and make particular reference to the joking and 'ribbing' that took place within the OT setting (Tanner and Timmons 2000). Similarly, informal conversation around music preferences, bathroom redecoration, gossip about patients and the calling of surgeons by their first names were also observed (Tanner and Timmons 2000). Given the sterile and controlled

environment of the OT, I found that that the joking and chatter not only served to defuse tension, but also contributed to a general feeling of 'team spirit'. It appeared that all those present (except me) seemed to 'get' the inside jokes thus indicating a sense of familiarity which has been described as a key element underlying team dynamics (Goffman 1959). This team ambiance however, did not completely absolve the presence and effects of hierarchy within the OT.⁴⁷ For example, apart from Santosh's whispered comments, it was mainly the surgeons and doctors who spoke openly during the operation, suggesting that doctors were empowered to speak 'out loud' and nurses less so. The two female surgical nurses, who appeared to be in their mid twenties, were quiet and concentrated, silently passing the required equipment to the surgeons and providing suction to clear blood.

Drawing upon Goffman's dramaturgical analogy, Riley and Manias have described the roles and actions that govern surgery as a well rehearsed 'performance' (Riley and Manias 2006).⁴⁸ Within the performance of the surgery I observed, the two surgeons played the 'lead' roles and were the focus of attention of the 'audience' (i.e. myself and the group of observers). The 'support roles' were not just occupied by the nurses and technicians who handled the equipment and instruments but also the anaesthetist who provided frequent updates to the surgeons. The 'end' of the operation was marked by the suturing of the patient and the surgeons' exit from theatre, upon which the nurses 'took over'. The two surgical nurses and a male technician transferred the patient onto a gurney and took him to the post-operative room next door where Annie and her ICU nurses extubated the patient, checked his vital signs and filled in the patient chart.

Although Riley and Manias view Operating Theatre nursing as a distinct area of nursing practice, the relationships between the health 'actors' during and immediately after the surgery provided an initial point of investigation into the delineation of occupational boundaries and importantly, a view into the working lives of nurses in the study setting. Through the site visits and analysis of the interview transcripts it was possible to identify some key features that underpinned the ways in which professional boundaries were constituted across the sites. Here, I was particularly interested in understanding 'who' does

⁴⁷ Hierarchies have been found to exert powerful influences on team dynamics in hospital settings. For example, in their study of team dynamics in the ICUs of two urban hospitals in Canada, Lingard and colleagues challenge the romanticized view of a team as a 'unified entity' by demonstrating power relationships in which individuals with distinct professional identities based on different models of care encourage cooperation, or alternatively impede cooperation, through continually negotiating 'rules of play' (Lingard et al 2004; 403).

⁴⁸ Goffman's work on 'impression management' analyzes social interaction as part of a 'performance' in which individuals and collective groups engage in different 'front stage' and 'backstage' behavior.

‘what’ and under ‘which’ circumstances and what this information could reveal with regard to whether these boundaries were perceived as fixed or negotiable within the hospital environment. Investigating the relationship between nursing and medicine in the study setting was also a means through which to generate information as to nurses’ understandings of their role in patient care and the importance of this to the construction of a professional identity in nursing.

Professional boundaries in hospital culture

Various studies have discussed the division of labour within hospital based care and typically describe a situation in which medicine is given more deference than other health professions including nursing (Freidson 1970; Stein 1967; Starr 1982; Walby and Greenwall 1994). Stein’s ‘doctor-nurse game’ is one of the most well known theories of nurse-doctor relationships and describes how nurses adopt a carefully managed and outwardly passive demeanour in their relationship with doctors so as not to upset the traditional medicine-nursing hierarchy by challenging doctors’ professional dominance (Stein 1967). Approaches to the study of inter-professional relations have moved on from this rather deterministic approach towards examining the circumstances in which nurses are able to demonstrate influence over medical decisions (Hughes 1988; Svensson 1996; May and Fleming 1997; Snelgrove and Hughes 2000). Stein has also revised his original position in a follow up study in which he acknowledged notable changes in the power dynamics operating at the level of decision-making around patient care, where nurses’ demonstrated a far more assertive attitude with doctors than he had previously found (Stein et al. 1990).

The analysis of power dynamics between health professions forms a key part of literature on inter-professional relationships within hospital settings and the construction and negotiation of professional boundaries (Walby and Greenwall 1994; Millward 1994; Mackay et al. 1995; Beattie 1995; Wicks 1998; Hancock and Easen 2006). For example, Alan Beattie uses the term ‘tribalism’ to describe the boundary conflicts that are increasingly occurring within the NHS in the UK as a result of the presence of different health occupations each advancing their own speciality and corresponding views of patient care (Beattie 1995).

Power dynamics, however, do not necessarily lead to open inter-professional conflicts between doctors and nurses over the division of labour in hospital based care. Davina Allen in her study of medical and nursing boundaries demonstrates how the realities of hospital life

mean that medical tasks are routinely taken on by nurses without signs of active negotiation or open inter-occupational conflict (Allen 1997). Allen's work builds on the study undertaken by Svensson (1996) in Sweden in which Svensson examined strategies of 'negotiation' in the context of 'face to face' interaction between doctors and nurses. Through comparing the interview narratives with her observations of nursing practice, Allen highlights an important discrepancy between the accounts of nurses and doctors and what she observed 'in practice'. For example, the interview narratives of nurses highlighted the occupational jurisdictions between medicine and nursing in which nurses drew a symbolic line between theirs and doctor's work. Through observing nursing work in a medical and surgical ward, Allen routinely observed boundary overlaps between medicine and nursing (Allen 1997). Drawing on Allen's approach, in order to understand the working lives of nurses in the study setting, I compared how occupational jurisdictions were depicted in nurses' descriptions of daily work (which often revealed instances of 'boundary cross-over') with field note observations of nurse-doctor encounters. This enabled me to examine the ways in which nurses constructed a professional identity through boundary maintenance, as well as to understand whether and how the medical-nursing boundary was maintained in daily hospital practice.

The following sections therefore explore how the occupational jurisdiction between medicine and nursing was depicted in the narratives, as well as the extent to which nurses could 'cross-over' from care into treatment, contest doctors' opinions regarding the management of patients and maintain professional control over the practice of nursing.

Boundary maintenance in practice: medical 'treatment' vs nursing 'care'?

During the site visits, I observed nurses engaged in a variety of functions that related to their area of nursing speciality (e.g. cardiology, psychiatry, obstetrics) as well as to the wards in which they were posted (e.g. delivery room, casualty, ICU, psychiatric ward). Consequently, nursing duties ranged from the transfer and monitoring of a patient following heart surgery, the antenatal care and delivery of uncomplicated pregnancies managed by the nurses working in the maternity hospital to the counselling and recreational activities conducted by psychiatric nurses. Nurses at most sites (except for the private outpatient clinic) were also typically responsible for helping patients go to the toilet, attending to patient hygiene and feeding patients. Ward sisters at the sites who were responsible for one or more

wards instructed and supervised the work of orderlies, cleaners and housekeeping that assisted nurses in carrying out activities related to maintaining cleanliness and hygiene.

The interview narratives of nurses across the hospital settings indicated the perception of a clear distinction between 'medicine' and 'nursing' and a subsequent distinction between the functions of doctors and nurses with regard to patients. As has been found in other contexts, nurses' testimonies defined the boundary between medicine and nursing through highlighting a 'treatment/care' divide (Walby and Greenwall 1994; Millward 1995; Wicks 1998, Snelgrove and Hughes 2000). They frequently referred to providing 'care' as the main role difference between themselves and their medical colleagues. Doctors were seen more as 'treatment providers' who came into contact with patients predominantly during their rounds or when called for medical assistance, whereas nurses' 'care' was seen as a '24 hour activity' that involved attending to patients' various medical, psychological and social needs during their stay at the hospital. Nursing care was thus viewed as advancing a 'holistic' approach in the management of patients as opposed to the 'disease oriented' approach attributed by nurses to members of the medical profession. As Jasmine, a nurse working in a central government hospital explained:

In medicine you are only treating the patient, but you are not close to the patient, the joys and sorrows you are not able to share properly with them. Of course, that kind of profession is different from nursing. I think that nursing has got closer attachment to the patient.

The interview and observational data across the sites indicated that medicine was largely responsible for major decisions regarding a patient's course of treatment. For example, doctors decided which patients were to be admitted as in-patients, the types of treatment required and when patients could be discharged. Nurses worked alongside doctors in functions such as undertaking admissions and discharge procedures, giving medicine, administering IVs, preparing patients for diagnostic procedures or surgery, overseeing hygiene and meals, monitoring vital signs and updating clinical charts.

At the same time, while nurses were responsible for carrying out treatment instructions laid out by doctors, many were able to conduct their own management of conditions not seen as requiring immediate medical attention- such as management of fever and administering analgesics for pain relief. In this sense, doctors often intervened based upon the monitoring and assessment of nurses, including nurses' observations of patients' responses to treatment.

Nurses also provided health education and counselling to patients and their families in at least two of the sites (Site 5 and 6).

Nurses' observations of patients were included in nurses' notes that were handed over to subsequent nursing shifts and frequently accessed by doctors. Doctors reported finding these notes particularly helpful as a record of patient care. For example as one doctor pointed out *"If you want to find a problem that happened in the ward, you look at the nurses' notes"*. Consequently, there was a sense of mutual dependence in the provision of treatment and care across the settings. This is somewhat unsurprising given that the range of tasks and skills required within a hospital environment would necessitate different health professions working together.

As Walby and Greenwall point out in their study on professional boundaries within NHS hospitals in the UK, the treatment/care divide is often more symbolic than functional in that such boundary lines may shift or be unclear when providing health care to patients within a hospital setting (Walby and Greenwall 1994). Similarly, Allen writes how a formal division of labour, in which doctors diagnose and nurses merely observe, would be impossible to sustain in reality. Consequently, she terms the unavoidable boundary overlap between medicine and nursing as 'de facto boundary blurring' and uses this term to describe situations such as those which require nurses to make diagnostic assessments of patients in the absence of doctors (Allen 1997).⁴⁹

Responses to interview questions that asked nurses to list typical nursing tasks as well as observations of nurses at the sites, strongly indicated that the boundary between doctors' 'treatment' and nurses' 'care' was frequently blurred in the daily routine of nursing practice. For example, boundary overlaps often occurred in response to the urgency of 'time' and the proximity of the attending doctor to the patient. Many nurses reported taking on medical tasks as required by the situation, such as administering IV antibiotics or inserting naso-gastric tubes when doctors were busy or unavailable, as well as performing emergency resuscitation while waiting for the doctor to arrive. This type of boundary crossing was seen as necessary and unavoidable in order to respond to the needs of patients that were assessed by nurses as requiring immediate attention. Consequently, this can also be seen as an example of the 'de facto' blurring of boundaries in that it was a regular feature of the work environment due to constraints related to physician's ability to respond to each and every patient as and when required.

⁴⁹ In her paper, Allen also looks at 'purposive' boundary blurring where nurses intentionally take on medical tasks such as initiating tests based on their own assessments of patients (Allen 1997).

Analysis of field notes, interview data and informal conversations with the study participants indicate that there are variations in boundary maintenance across different hospital contexts. For example, one doctor noted that in one hospital where she trained and worked for many years, nurses were mainly 'observers' and contrasted this with her experience in another hospital where nurses were competent in clinical tasks such as intubation - a function typically performed by doctors. As could be expected, she and other doctors I interviewed were not in favour of highly restricted roles for nurses as this was seen to increase doctors' workloads and would have negative consequences for patients. Dr Chowdry noted:

In the hospital where I trained nurses were not allowed to do any procedures at all. Their work was only to document, document, document. Even starting IV lines, it was to be done by the doctors. The minute they came on duty, handing over was one big process from the previous shift to the next shift. Everything was written, written, pages and pages of written work, but nothing practical ... I was totally against that because that is not at all good ... then in (name of hospital) here in Bangalore it was the opposite. Nurses there are extremely good, they are even good at intubating children.

Evidence of different boundary settings between medicine and nursing also emerged in the work histories of nurses. Some nurses complained that in former appointments, hospital regulations meant that they were able to do limited clinical nursing and had to follow doctors' orders even to undertake routine nursing functions. For instance, Sister Deidre gave the following account of her experience when accompanying her husband for admission at a well known private hospital in Bangalore:

See, for example, from my own personal experience I will you. When my husband was admitted to Hospital X, to give a steam inhalation the nurse was asking for a doctor's order. I told her 'Excuse me. This is purely a nursing function. Why do you need a doctors' order for this'? The nurses who are working in the corporate set-up, they feel in brackets that they have to follow only doctors' orders. They will not do anything independently. Even to give a steam bath, you don't need a doctor's order!

In some hospitals therefore, the setting of boundaries follows a more formal division of labour between medicine and nursing, where hospital management and staff adhere more strictly to professional and hospital regulations. In other hospitals, nurses reported being able to demonstrate greater autonomy over decision-making regarding patients than their sisters working elsewhere. However, even within contexts with more regulated boundaries between medicine and nursing, nurses were not lacking in agency. Three key features of the work

environment across the hospital settings were found to influence nurses' ability to secure greater autonomy in nursing practice and to cross over into medical territory.⁵⁰ These were the institutional context in which medical/nursing care is organized and particularly the division of labour between government and private facilities, the clinical setting of nursing work, and the strength of inter-personal relationships between nurses and doctors. Although both institutional and clinical settings can be seen as structural conditions of the work context and in a sense, are less negotiable than inter-personal relationships, these conditions were found to create an environment that facilitates the ability of nurses to cross the traditional boundary between medicine and nursing.

Public vs private work settings and the organization of labour

Between 'public' and 'private' institutional settings, doctors and nurses were perceived to take on different responsibilities. For example, nurses who had worked in the government sector frequently talked about having more independence than was typically permitted in private sector hospitals. The organization of maternity care provided a good case study within the data in order to examine this issue in more detail as it is an area in which both doctors and nurses possess clinical knowledge yet where nurses demonstrated different amounts of responsibility across the sites.

In government maternity facilities, nurses carry out pre-natal checkups and routinely conduct normal deliveries without the intervention of doctors.⁵¹ In private hospitals, particularly those catering to the upper middle class and wealthy, these functions are undertaken by obstetricians with nurses assisting them.⁵² Sister Deidre explained:

Deidre: See, nowadays, all normal deliveries are conducted by nurses in government hospitals. Whereas in private hospitals, even normal deliveries are conducted by doctors only. That is because of the charges they are charging. Because a mother pays 45,000 – 50,000 rupees for a normal delivery in a private

⁵⁰ By autonomy, I refer to the exercise of independent decision making around patient care which may require nurses to make decisions or undertake actions that involve crossing over into the medical domain.

⁵¹ Unlike countries such as the United Kingdom, there is no separate midwifery qualification in India. Rather, midwifery is included in the curricula of both the General nursing and Midwifery (GNM) and Bachelor of Science in Nursing (BSc Nursing) training programmes. The majority of nurses interviewed in the government maternity hospital held a GNM nursing qualification.

⁵² There is also an increasing trend within corporate hospitals to offer special maternity 'delivery packages' that includes the costs of delivery, hospital stay, neonatal tests, antenatal and post natal physical therapy etc and cost around 50,000 rupees (approximate 1,000 USD). Some of these services advertise themselves as 'boutique birthing centres'.

hospital. That is why gynaecologists insist that they should conduct the delivery. And there is a paediatrician on standby, gynaecologist. So, both of them are there and the nurse is only there to receive the baby.

SJ: And in the government set-up how is it?

Deidre: See, when a woman comes for labour, a nurse there decides if it is a normal delivery or not. If there is a complication, then she will send for the doctor. Then the doctor will come and attend. If there is no complication she will go ahead and deliver the baby and she will tell the doctor that the baby has come and give a report.

Rather than being related to the technical ability of nurses to manage pregnancies, the difference in responsibilities in this area is influenced by the organization of medical care within fee paying and public hospitals and the corresponding levels of patient control over service delivery. Government hospitals and some mission hospitals provide free care to predominantly poor patients and are often overcrowded. Doctors therefore rely upon nurses to take over routine ante-natal checkups and deliveries. Consequently, in these settings patients are largely unable to demand their choice of health provider, with such decisions determined mainly by treatment needs. Consequently, nurses typically manage routine pregnancies with doctors intervening in cases requiring further attention such as with anemic patients, in cases of obstructed deliveries, or where there are neo-natal complications. As demonstrated by Deidre's account, in the government setting of maternity care, nurses' assessments of patients typically determine whether a delivery is considered 'routine' or requires the attention of medical staff. In private hospitals, however, patients are more able to demand a doctor to manage the entire pregnancy as they are paying for the service. For example, Soraya, a 22 year old nurse, who had previously worked in a government hospital, compared this with her experience working as a nurse in a private sector hospital:

In government hospitals, nurses used to get the opportunity to conduct deliveries. But in the private hospitals, they will not allow, doctors will conduct deliveries. But in the government hospital, sisters will conduct. If any difficulty the doctor will come and assist us ... Like here, private hospital, the people they get scared 'Oh sisters are doing, better it is a doctor, means it will be safer by a doctor'.

As illustrated by the extract above, the division of labour between nursing and medicine in these contexts is also influenced by patient expectations in terms of which tasks can acceptably be carried out by a nurse. In private hospitals catering to the middle class and wealthy, patients expect to be examined and treated by doctors. Nurses therefore are less able

to exercise clinical independence than in a government context with fewer staff, a larger volume of patients, and less 'patient control'. As private patients are paying for the service, nurses felt that it was harder to negotiate greater professional authority especially in situations where they were challenged by patients. As Soraya noted:

Practically we can do much better (in government) than in private. Because private once we come, some people will tell us they refuse it (our care), and we have to agree with them. But in the government, no-one will refuse, whatever we want to do, they will allow us to do. And they will be very happy that okay someone is coming and caring for us.

This relative lack of control by government patients over state provided care however, does raise some questions over the quality of care in these settings. Interviews with nurses and doctors indicated that a great deal of maternity care is provided by student nurses undertaking clinical rotations in government hospitals. Although mobilizing student labour to boost the nursing workforce in hospitals is not unusual and has been reported in other settings (Johnson 1999; Melia 1987), the narratives of some nurses that indicate they were working in an unsupervised capacity is cause for concern. For example, Santosh recalled delivering babies in the first few days of his clinical rotations and highlights the inherent risks involved in the lack of proper supervision of nursing students:

I was on labour duty, the first day I saw what happened and cases were coming in. I saw the staff, students taking care of a delivery and the next day when I was posted, see we were just observing, we didn't know anything about what's happening. The first day three of us were there, the three of us and the matron. The second day when I came, there were no patients, there were no staff, nothing. We were just simply standing there, we didn't know what was happening. Suddenly two or three cases came in. Suddenly! So, we were forced to do it. So, we did without any knowledge. So, with previously what I saw, I was learning then I was doing. I delivered three babies in one day! ... Yes, it is highly risky because we are very very unskilled isn't it! If something goes wrong, it is dangerous for the baby and for the mother also. But we were forced to do it as we could not do nothing ...

Although quite extreme, Santosh's account is an example of the 'hands on' experience nurses working in government settings recall being obliged to take on from early in their nursing careers. Working in the government sector is therefore perceived as providing nurses with more practical nursing skills due to the pressure on nurses to work independently due to their higher case loads than nurses working in the private sector. Consequently, Deidre noted how she preferred to send her students to learn maternity care in government hospitals:

See, even when I send my students to conduct deliveries in government hospitals, they are also giving episiotomies and learning how to do stitching.

Interestingly, both in the formal interviews and in informal conversations, doctors also mentioned how they learned how to deliver babies by watching nurses within government hospitals. Due to the high volume of patients in government facilities, nurses working in this setting were seen as particularly skilled in handling maternity cases. One doctor explained:

In the government set-up, they do it because there are so many deliveries. Doctors are around but like, we also learn from the nurses how to conduct them, some ways to deliver. We have learned from the nurses. I mean, they are good.

This extract provides an interesting instance of nurses being seen to possess greater 'expert knowledge' than doctors. The specialized knowledge acquired by nurses in carrying out large numbers of deliveries is translated into increased autonomy and vice versa. Thus, nurses are able to maintain a position of authority and control with regard to this aspect of health care delivery.

'Expert knowledge' and the clinical setting of nursing care

The ability to conduct independent assessments of patients, undertake certain medical tasks and demonstrate higher levels of professional responsibility also appeared to be based on the clinical setting of nursing work, thereby suggesting a hierarchy of responsibility in nursing practice. Here, general ward nursing was seen at the bottom of this hierarchy in both public and private work settings. Nursing work in this context was perceived as less 'technical' and mainly involved essential nursing duties such as bathing, administering medicine, providing meals and overseeing the general comfort of patients. Consequently, ward nursing duties were typically assigned to junior nursing staff, including recent nurse graduates undertaking an initial obligatory training period in the hospital. Doctors and senior nurses⁵³ set the parameters of care and provided instructions that nurses assigned to the wards were expected to follow. The potential for boundary crossing into medical territory was therefore far less common in this setting.

⁵³ This particularly includes sister 'in-charges' who supervise nursing staff in one or more wards.

Providing essential nursing care on the wards was perceived as the least attractive setting for a nursing 'career' in that it was perceived as low status work and often described as 'boring'. For example, one nurse described providing care on the general adult wards as involving little more than 'administering a tablet'. Being assigned to ward duties was also considered to be less marketable in terms of securing employment in other hospitals both in India and abroad. Therefore, a higher premium was placed by nurses on specialized skills that were considered to be in short supply and thus, 'in demand' rather than routine nursing skills that could potentially be undertaken by auxiliary categories of health workers, such as auxiliary nurse midwives (ANMs) or those with considerably less training.⁵⁴ Other speciality areas, such as working in the OT as a surgical nurse, for example, were seen as an opportunity to acquire skills and experience in a specialized setting, skills that could be easily transferred to other hospitals. At the same time, working as a scrub nurse in the OT was not viewed as bringing more professional autonomy as nurses in this setting mainly provided support and assistance to surgeons.

Rather, at the other end of the spectrum of professional responsibility was the status awarded to nurses working in critical care. The interview narratives with doctors and nurses illustrated that nurses working in the ICU were considered to be the most experienced and 'elite' of nursing staff. For example, in discussing areas of nursing recruitment, the medical director and a visiting consultant in the cardio-thoracic hospital explained that they put their 'best nurses' in the ICU.⁵⁵ The reason for the high professional status awarded to critical care nurses is the level of independent responsibility associated with providing care to critically ill patients. As Santosh explained:

Actually the ITU (intensive thoracic care unit) nurses have got more responsibilities because they have been allotted a patient- one or two patients, so it's completely in their hands. They are responsible for whatever is happening, they will be questioned. So they have to be more vigilant always. But in the OT it's not that, you are working with doctors. So whatever happens you have doctors with you.

⁵⁴ Some smaller hospitals and nursing homes employ auxiliary nurse midwives (ANMs) or those with some former experience working as nurses 'aides' to undertake routine care duties in general nursing, such as bathing patients, providing meals, administering medicine and attending to the patient's general comfort. In one hospice I visited, there were 7 registered nurses, 10 auxiliary nurse midwives (ANMs) and 15 staff members who were referred to as 'Health assistants'. The latter were women from surrounding villages who were trained by the hospice over a period of six months to provide basic care.

⁵⁵ Discussions with hospital staff indicated that there are two main ways in which nurses can be posted to the ICU. Either they can undertake a Diploma in critical care nursing issued by the Indian Nursing Council and work directly in the ICU or they can be posted to the ICU for training following experience in other areas of nursing practice in which they demonstrate competence in technical nursing skills and an interest in working in critical care nursing.

For some nurses therefore, working in the ICU was aspired to in that they were able to demonstrate a higher level of responsibility over patient care than in other areas. For others, however, working in this setting was not desirable as the level of responsibility it entailed was 'intimidating'. The following is an extract from a conversation with two nurses, Rita and Shalini (both 29 years) who worked at the private outpatient clinic and talked about their previous experience working in an ICU.

- SJ: And in X hospital, where did you work?*
Rita: ITU, the intensive thoracic care unit, cardiac ICU. The patients were unconscious, most of the patients...So some cases we can tolerate. We are also scared about the patient, because they are so worried. In this stage, the behaviour will be entirely different and we should be alert always.
SJ: So you are saying that it is more stressful when your patients are unconscious as you just don't know what is happening?
Rita: We have to stay carefully to watch the patient.
Shalini: Every minute. Not every minute, every second.
Rita: We cannot sit also, we are standing.
Shalini: We cannot close our eyes
Rita: It is very horrible
Shalini: Only one day I was there (laughs)

In addition to being trained in more clinically advanced nursing skills, ICU nurses were expected to both follow doctors' orders as well as assess those orders in relation to the patient's status. In this respect, critical care nurses could avail of increased professional 'space' in which to make autonomous decisions regarding a patient's condition and course of treatment. When I asked Dr Desai, a doctor working in the cardio-thoracic ICU, what kinds of skills he expected from ICU nurses, he replied:

First of all they should be able to follow instructions. If something is instructed to them, they should be able to follow up and they should be able to think before they follow those instructions. So, in the sense that if an order is given, their first duty is to follow the order and at the same time, they should also be able to think whether the order is right or not.

Both he and Dr Tandekar gave examples of being questioned by ICU nurses over drug prescriptions for patients. As Dr Tandekar noted:

I had somebody pointing out to me that this drug might further diminish the white cell count in a patient whose white cell count was already diminished. I was so glad when they came up with that.

Similarly, Dr Desai recalled:

We had written out a prescription and they (the ICU nurses) were quick to point out that as this patient is asthmatic, should we really give this drug?

In addition to specialized settings such as critical care, nurses working in clinical specialties also appeared to demonstrate more authority and control over nursing work and exert greater levels of autonomy than nurses working on the general wards. Some evidence of this was found in the context of psychiatric nursing. Like nurses at the other sites, psychiatric nurses also reported following doctor's treatment plans. Within this setting however, particularly on the psychiatric wards, I observed nurses taking the lead over a wider range of activities with patients than may be possible in other settings. These activities included art therapy sessions, health promotion talks with patients and relatives, and physical exercise. Given their close supervision and interaction with patients, psychiatric nurses were able to demonstrate their knowledge of a patient's mental health with doctors thus establishing a certain authority with regard to patient care.

The following field note extract recounts a visit to the closed female psychiatric ward where I observed a recreational session. In the incident, the knowledge of an on-duty nurse was used to advise a doctor regarding a patient's mental state:

I was sitting and watching patients going through newspapers, playing board games (looked like Snakes and Ladders) and looking at picture books when I heard wailing from the corridor outside the room. A middle-aged woman was lying on the ground crying hysterically. Was a bit alarmed! The nurses didn't appear concerned in the least. A passing nurse patted her and said a few reassuring words, but otherwise there was no other intervention. One of the junior doctors on his rounds came by a few minutes later and asked 'What's wrong with 'Geeta'? Why is she crying like that'? The nurse sitting at the main desk next to me replied that 'Geeta' became anxious when waiting for her meals and cried 'like clockwork' when her snacks or meals were even a few minutes late. She told him 'don't worry, it will pass, you'll see'. He seemed satisfied with this explanation and after the exchange of a few pleasantries continued on his rounds.

As few of the nurses working in speciality areas had specialized qualifications such as Diplomas and Master level degrees, such specialized knowledge was built up over time, and therefore the ability to make more autonomous decisions with regard to patient care was often

different for junior and senior nurses working in these settings. Consequently, another key factor underpinning the exercise of professional autonomy was the inter-personal relationship between nursing and medical staff, in which senior nurses were able to demonstrate more authority regarding patient care than junior nurses and, in carrying out their work, were also more likely to undertake medical tasks.

'Doctors' favourites': Inter-personal relationships and professional autonomy

For many nurses, years of experience working in one area enabled them both to build up clinical skills and medical knowledge as well good inter-personal relationships with medical staff. This often led some nurses to be labeled as 'competent' by doctors and thus trusted to take on a greater range of medical activities. Both the interviews and informal conversations with doctors indicated that they were aware of who was a 'good nurse' and therefore capable of doing X, Y and Z. In the interview extract below, Dr. Chowdry mentions that nurses who took over some medical functions frequently 'hang around' with doctors during their night duty, indicating that spending time with doctors is rewarded through being taught additional medical skills.

- SJ: *I didn't think for example that nurses are allowed to do intubation.*
- Doctor Chowdry: *That is they have learned when we are on duty. And if there is an emergency they can't take a chance. If they find that a baby is turning blue they can do that to save the life of the baby.*
- SJ: *Yes, well that is a good thing isn't it?*
- Doctor Chowdry: *They should be aware of it. I mean, they should at least realize what the problem is, like for example the child is black and blue and er do suction, put a mask, do oxygen etc. If they do all that, that would be great ... Intubate, not but er one or two nurses there who have been working in the surgical pediatric unit for a long time er*
- SJ: *They feel comfortable doing it?*
- Doctor Chowdry: *Yeah, they hang around with us on night duties etc.*

As doctors are legally responsible for medical decisions, 'trust' was a core component when allowing nurses to undertake responsibilities that crossed over into medical territory, especially where such boundary overlaps were not in line with hospital regulations.

The interviews demonstrated that age and seniority acted upon the extent to which nurses were given more autonomy in decision making by doctors. Older and more senior nurses tended to exert a greater measure of professional control than younger nurses, and showed a greater ease of communication with doctors. 'Being at ease' with doctors also meant that they were more empowered to question a doctor's instructions or able to take over certain medical duties without having to specifically request permission. Some younger nurses therefore felt quite disempowered in their relationships with doctors compared with their 'seniors'. For example, Prabha's (25 years) sentiments below depict the effects of 'hierarchy' upon her ability to interact with doctors:

Most of the time we feel dominated by them (doctors). So they just come and say 'Okay this is what we want, you do this'... Sometimes we are ignorant of why they are telling us we should do that, but still we cannot question them 'Doctor why is it we have to do that?' They'll not be in a position to answer us. They are just telling and we are just doing it. So, I don't like such type of balance.

During the interviews I observed that some younger nurses, particularly recent nurse graduates in some sites were very shy, whereas older nurses, particularly in their 40s and 50s were much more relaxed and confident. Indian society is one in which seniority is most often denoted by age and where young people are taught to be respectful of their elders. Consequently, it did not surprise me that young nurse graduates are less likely to challenge doctors in that they may feel intimidated both personally and professionally. At the same time, demonstrating greater confidence in talking to doctors may also be the result of working in a hospital over a period of time in which nurses are able to build personal relationships with medical staff. For example, Prabha and her colleague Kumari (24 years old) highlighted that as they had only worked in the hospital for 6 months they had not yet forged strong bonds with the doctors, unlike senior nurses who had worked with the medical staff for a longer time. Furthermore, the strength of inter-personal relationships may also be influenced by the size of the hospital, where smaller set-ups may encourage doctors and nurses to form closer personal relationships than in large hospitals with hundreds of staff.

During my visit to Site 1, I observed that Annie had a very good relationship with the medical staff. She was frequently requested to consult with Dr Tandekar, the medical director, and other doctors about patients, organized village camps with Sister Josephine (the nursing superintendent) in which medical and nursing staff travelled to rural areas to provide diagnostic services for heart ailments, and was responsible for training new recruits in cardio-

thoracic nursing. The high esteem with which she appeared to be held by Dr Tandekar and the relaxed manner in which she interacted with doctors, indicated to me that she was a 'favourite' of the medical staff and as such, was given greater responsibility in patient care at a relatively young age. Annie held an in-charge supervisory position in the ICU and worked closely with Sister Josephine in overseeing nursing staff in the hospital.

Although good interpersonal relationships and perceived competence were seen to denote greater autonomy in nursing practice, these factors did not completely absolve the presence of the traditional hierarchy between medicine and nursing in professional relationships, particularly as accountability for patient care lies with medical rather than nursing staff.⁵⁶ For example, as Vandana, a 58 year old nurse who worked in the private teaching hospital told me:

Yes, when you are a senior nurse, junior doctors are also respecting. Because in age wise, I am the senior, but in the profession, they are the seniors.

The power dynamics between medicine and nursing were also evident in Annie's account. In her interview, Annie highlighted that while she followed doctors' written instructions, she was able to double check these when in doubt. Interestingly however, Annie frames her questioning of the doctor's order in terms of her 'confusion' rather than pointing out the mistake directly. As demonstrated by the extract below, she also accounts for this questioning by referring to the interests of 'patient safety':

Because especially in the medicine cards and all, if they are writing the medications but not putting the signature, in that situation, we will tell them to come here and put their signature and go. Even after seeing the X rays and after seeing the ECGs and even the ventilator set-up also. Once after setting up the ventilator we used to tell them to check it once and put their signature. So, it's like safety measures. We have to be on the safe side always. We have to take care of the patient. We have to obey the doctor's orders but at the same time, we have to be on the safer side also. Sometimes if they write something wrong, if we have a doubt about that, we can tell them 'Sir, I have one doubt' like this, for example if they are writing one injection, if it is supposed to be given as IM (intramuscular) and if they are writing by mistake 'IV' (intravenous), if we are aware of that we can tell them 'Sir, we have one doubt, you have given IM or IV'?

Annie's account therefore has echoes of the 'doctor- nurse' game in the way she tactfully questions the doctor's instructions without contradicting him directly. At the same

⁵⁶ For example, doctors can be sued for medical negligence under both the Indian Penal Code and the Consumer Protection Act.

time, through the act of questioning and keeping 'patient safety' as the main focus, she is still able to exercise some control over the process of patient care.

Managing professional relationships

Across the study sites, almost all nurses highlighted good working relationships with doctors as well as with other health staff such as physiotherapists, dieticians and technicians. The majority of nurses interviewed described positive working relationships between doctors and nurses, some using the word 'team' or 'family' to describe inter-professional relations. The reference to 'teamwork' when describing nurse- doctor interaction was most frequently used by psychiatric nurses. For example, Sonya highlighted how doctors typically discussed treatment plans in a collaborative manner, through what Svensson refers to as 'sitting rounds' (Svensson 1996).⁵⁷ In the following extract, Sonya also compares this approach to what she perceives as the unilateral and dominant attitude of doctors working in the private sector:

Because it is a multi-disciplinary approach here, patient care. It is not that the doctor comes and orders. Because private sector that is there 'I have written, you carry out', like that. Here we say 'No you (doctors) are advising, the staff (nurses) will take care' and our consultants, you know the senior doctors, they will come and directly talk to us saying 'Sister, so and so thing we are planning'. And when the rounds are going on, it is part of a team, nurses also, one of the psychiatric nurses will also go and sit in the rounds. So psychologists, social workers, junior doctors, senior doctors then our nurses. All of us sit and review the patient.

Across the data set, nurses reported few examples of doctor-nurse conflicts. Where such incidents were reported, they typically involved doctors 'getting angry' or 'scolding' nurses over mistakes in patient care. For example, according to Lizzy:

If some time we give some medication also, in some emergency situation, then they'll (doctors) ask 'Why have you given these medications'? And then it is hurting to the profession, means we will feel very bad. Then we'll think 'Oh, these many years I am working as a nurse also, what they are thinking, that we don't know anything'?

Although few, these examples of negative nurse-doctor interactions shed a great deal of light on the wider normative nature of power relations between medicine and nursing in which doctors are more empowered to reprimand nurses rather than the other way around. Dr

⁵⁷ Svensson also refers to 'sitting rounds' as an example of nurses' increased potential for negotiation and their ability to actively influence treatment decisions.

Modi, the director of an outpatient clinic felt that only senior nurses were really empowered to question doctors, whereas younger nurses were often, as she put it 'yelled into submission' and expected to carry out whatever instructions were given:

There's an intimidation factor in India. So they won't necessarily communicate that 'Okay, well this patient's blood pressure is really low'. They kind of come and say (whispered voice) 'blood pressure eighty by sixty'. They are not as forthcoming and forthright with their views as Western nurses are. So in terms of communicating with doctors, there is always a level of deference maybe until they get to be really senior nurses and they are more comfortable telling a doctor 'No, no, no, you really need to look at this patient.' So it can affect the medical care in the sense that they are not communicating with the doctor because they are intimidated, because they haven't been trained to speak up and they don't see themselves as being the opinion drivers, they see themselves as being the 'worker bees'. They are doing the work. The doctor says 'put the IV', they put the IV. They don't question the system or the doctor or the care or is this dose okay or not okay. I think in India they are not trained to question.

The unequal power relationship between nurses and doctors may be explained by the normative expectations attached to class and gender aspects of medicine and nursing, in that doctors are generally from middle to high-income backgrounds and nurses are mainly drawn from the lower-middle class, thus demonstrating a form of social control in addition to professional control. Similarly, as we have discussed earlier in this thesis, nursing is associated with 'women's work' and medicine with 'scientific knowledge', so that the dominance of medicine over nursing reflects a gendered occupational hierarchy in which doctors enact authority over nurses in hospital life.

Interestingly, interviews with a few of the male nurses revealed their opinion that the unequal professional relationship between nurses and doctors was largely a product of the gendered hierarchy in India. This was specifically related to women's ability to speak out or question authority in Indian society and their adherence to traditional gendered behaviour. In his interview, Professor Nande highlighted that the control exercised over women in India by their husbands, largely explained the control exercised over nurses by doctors:

For females the problem is that, suppose you have joined nursing, you are controlled by your husband, not you. That is the major problem. He will not be knowing what is happening in nursing but you will be controlled by your husband. That is the major problem why we have become subordinate, why the profession is not high. See, I am a man. I am here and I can take my decision boldly. If something is not er, or the doctor is doing a problem, I can give a back answer. The females, they are good, they are technically very strong, very good women, but they will not give back answers to a doctor. That's the problem.

Similarly, Santosh told me that female nurses are more submissive and follow orders with 'no opposition from their side', whereas male nurses tended to challenge authority more. Malika, a nurse working in the same hospital, agreed that male nurses were more 'empowered', saying:

I find they (male nurses) are much more open to our seniors than we are. We will put forward our respect, but er male nurses are much more open. They are much more bold.

The perception of nurses as being relatively submissive to doctors can perhaps be explained by traditional gender relationships in India in which women are more guarded and careful in their interaction with men in public settings so as not to invite any unwelcome suggestions of impropriety. Consequently, they may be less likely to engage in informal banter as part of relationship building with doctors than their male colleagues - like that shown by Santosh in the OT. As stated earlier, I found that both young female and male nurses (in their early to mid- twenties) tended to be very shy and that older nurses of either sex were much more confident and talkative. The ability to 'speak out' therefore may be a function of age, experience and fluency in English⁵⁸ as it may also be a product of gendered behaviour. Although I observed that male nurses exhibited a more informal interaction with male doctors, which suggested that they were not constrained by traditional gender boundaries at a personal level, it did not appear that being male necessarily enabled them to transcend the unequal gender power relationship between medicine and nursing. For example, Karthik a 34 year old male nurse recounted how uncomfortable he felt when shouted at by doctors especially in front of patients or other staff. His response to this however, was to 'keep quiet':

Karthik: These are doctors that are shouting in front of patients, then in front of other staff. Sometimes we are a senior person in front of our juniors, sometimes they are scolding and shouting.

SJ: So, what would you do when they were shouting?

Karthik: Then I would simply keep quiet. Otherwise again it will be a problem. But only out of ten, one doctor is like that. Others are very good.

⁵⁸ English is typically the medium of communication in private hospitals. Government hospital staff were observed to converse in both English and Kannada.

Professor Nande also recalled an incident in which he felt both personally and professionally undermined by a doctor in which his masculinity did not compensate for the difference in professional status, where he was seen as 'just a nurse' and consequently, a member of a subordinate occupation. Interestingly, when Professor Nande left the hospital to take the helm of another hierarchy (that of an educational institution) he recounts experiencing greater respect from the same doctor, which he relates to a new title and qualifications as part of a new identity, that as a Principal of a nursing college.

My experience, one example I will give you. One of the anesthetists, I assisted for a caesarian section and he was very happy after the delivery. He invited me to a party, 'Mr Nande, on so and so date a party will be there, please join'. When the date came, he came to me and said 'Mr Nande, you don't come. All doctors are coming for the party'. Because I am a nurse, he avoided me. After 15 years I met him, and you will not believe, the same person, because of my qualifications, because of my position (principal of a nursing college), he was addressing me 'Sir'. The 'Mr Nande' is converted as 'Sir'!

Like the accounts of private nurses who were very critical of the behavior of government nurses towards patients, the doctors interviewed at one of the private hospitals portrayed their working relationships with private and government nurses as being different, and reinforced the stereotype of government nurses as being 'rude' and 'uncooperative'. During the course of a joint interview with two doctors, I asked the question as to whether they had observed differences in the nursing care provided in government and private hospitals and whether they perceived any differences in the training of nurses. Although both doctors stated that they did not see any notable differences in training, they attributed a major difference between government and private nurses to the 'attitude' of government nurses that was reflected in their interaction with medical staff.

Doctor Chowdry: They are difficult to deal with! They are difficult to deal with you know! They don't care about anything. Because their job is secure and they are not answerable to anybody. So, usually they like to do whatever they want.

SJ: When you say 'not answerable', they are not answerable to doctors?

Doctor Chowdry: Doctors also, yeah.

SJ: So, how is the relationship? Have either of you worked in a government hospital.

Doctor Bhavan: Yes. It is difficult to deal with those people. You can't have a say. They rule the world. The doctors are second rate to the nurses (laughs). You have to beg them 'please come and help me'. You have to speak to them in a nice way to get something.

The power imbalance in government hospitals between poor patients and medical staff in which poor patients generally exercise less control over hospital care as they are not paying for their care was seen as leading to corruption and poor standards of service in the government sector. For example, nurses working in the private sector tended to account for the poor public perceptions of nursing by criticizing the behaviour and attitude of 'government nurses', who were described as taking bribes and talking rudely with patients, thereby giving all nurses 'a bad name'. For example, Bhavna, a nurse working in a private teaching hospital referred to perceptions of corruption among government nurses:

Once one person will be taking (bribes), everybody will get a bad name - 'Oh, see, government nurses, they will do like that.' I don't like that. Unnecessarily we will get a bad name no?

Ashwani, who works in a private hospital, described government nurses as showing a lack of compassion with patients:

Suddenly they will get very angry, like that. If a patient is asking anything, means they will scold. In there, that government hospital, they are scolding. Every day, a patient is asking means they will scold.

In their interviews, private nurses frequently sought to distance themselves from the image of the 'government nurse' by emphasizing how things were 'different' in a private hospital environment. For example, Joy emphasized that she would never consider working in a government hospital, insinuating that government nurses were also of a lower social status:

Well I think that the government hospitals' standard, where the actual social status of nurses is not as, you know, nursing in government hospitals is looked at as a profession that people didn't want to go into. You went in if you couldn't get the qualifications in anything else, if you couldn't afford to go to university, you know, that kind of thing. The hospitals that I went into, it was completely different.

In the interview extract below, Annie and Josephine describe how the general public was able to 'tell the difference' between private and government nurses. Interestingly, in their account, both draw upon stereotypes of nurses, where they depict private nurses like themselves as 'angels' and government nurses as 'battleaxes'.

Annie: People are thinking like that. If any people are behaving in such a way 'Oh, you are behaving like a government nurse'.

- SJ: *So, they are able to differentiate between government and private nurses?*
- Annie: *Yes! The public now are able to differentiate between government nurses and the private nurses.*
- SJ: *So, when you say 'behaving like a government nurse'?*
- Annie: *It means behaving very rudely and without any manners. They will say 'the sister is behaving like government nurses.' There is a clear picture in their mind that government nurses are very fat and sitting behind a desk (laughs)*
- Josephine: *Old, lazy, they don't do this and that. And the patients they see the difference. And sometimes when they go, we can see tears in their eyes. And they say that even their own children have not taken such good care of them.*
- SJ: *Here?*
- Annie: *Not only here, in private institutions. They say 'you people are taking such good care of us. You are not human beings, you are like a god.'*
- Josephine: *'You are like my mother' even the old people will say that. 'Sister, you are like my mother. Definitely you will get a seat in heaven.' (laughs)*

Government nurses also sought to distance themselves from the popular image of the 'government nurse' by counteracting accusations of corruption and negligence through highlighting unfair coverage in the media, and the difficult working conditions in a government hospital. For example, during a visit to a government hospital which catered specifically to government factory employees and their families, I spoke about allegations of corruption in the government sector with Radha, a nurse supervisor. Radha told me that she knew such events occurred and that they were often reported in the newspapers but emphatically denied witnessing any corruption herself saying that she would not tolerate such practices if she encountered them. During a discussion between myself, the finance director of the hospital and Radha, the finance director told me that the payment of bribes from patients was a problem in government institutions, and said that this was more due to certain 'personalities' rather than being encouraged by the institution itself. Radha was very upset by this statement and angrily responded by saying that nurses did not engage in 'this type of behaviour' in the hospital. Similarly, Karishma, a 54 year old government hospital nurse felt that the public image of government nurses was unfair, especially as it was reinforced by sensationalist media stories. In the following interview extract, Karishma also highlights the heavy workload of government nurses to explain why providing care in this environment is more challenging than the private sector:

- Karishma: *Sometimes we feel 'why did we come to this nursing profession' because the public are always blaming nurses.*
- SJ: *Yes, can you tell me about this public image*
- Karishma: *Because the media people are giving a bad name to the profession*
- SJ: *Like what do they say, these media people?*
- Karishma: *That they will talk rudely with the public and that there is corruption. That they are not taking care of the patients. They don't think about what is the staff pattern. For one hundred patients, one nurse. How can she give care? In the labour ward, for two patients, one nurse must be there. Here twenty deliveries in the day time are taking place, at night also. Only four nurses are working. How will they work? They are also human beings. It is very difficult to work ...*
- SJ: *And why are they saying there is corruption-*
- Karishma: *Because they are not er, they are non medial people. They don't know about the medical aspects. So whatever the public will say, they will expose it. They want only sensational news. So many operations are taking place. So many deliveries are taking place and there will be no contraindications. But if there will be one contraindication, they will expose it badly. They will highlight it.*

Consequently, although government nurses were seen by nurses and doctors as having more professional space in which to make decisions, their relative autonomy compared with nurses in the private sector was depicted as a 'threat' to patient care rather than a 'benefit'. In a sense therefore, the greater autonomy of government nurses rendered them more vulnerable to public scrutiny and being used as 'scape goats' for some of the wider systemic problems in the public health care system. This association with corruption and poor levels of care greatly tarnished the image of government nurses. Consequently, all nurses, whether government or private sought to distance themselves from the popular stereotype of the 'government nurse'. The ways in which nurses therefore resurrected the image of nursing through their narratives is discussed in more detail in the sections below.

Maintaining the nursing boundary

In their 1950s study of American nurses, "Twenty thousand nurses tell their story", Everett Hughes and colleagues point out that:

More than most institutions of civil life, the hospital with its array of titles, uniforms and graded quarters and facilities makes it quite clear that the people who work there are not thought of as all alike or equal in power and importance but sorted into publicly acknowledged ranks. (Hughes et al. 1958: 62)

In 21st century India, this description of hospital life is also relevant. In the busy environment of the city's large hospitals, patients and visitors mingle with doctors, nurses, orderlies, receptionists, housekeeping, cleaning staff and other hospital employees. Consequently, the uniforms of hospital staff serve to differentiate between those who work in the hospital and those who are just 'passing through', and also act as an identity badge for relatives enquiring about patients or requesting assistance.

Nursing staff in four of the hospitals wore traditional white nursing uniforms and hats (in one hospital they wore a checked uniform), and doctors could be identified by their white coats and stethoscopes. Despite the uniforms, however, identity mix-ups occasionally occurred and were most often due to gendered cultural assumptions around the sex of health professionals. For example, female doctors were sometimes mistaken for nurses and called 'Sister' on the wards, where this may be explained by the association between 'being female' and working in a hospital and 'being a nurse'. Similarly, as male nurses wore white trousers and shirts they were sometimes mistaken as doctors. As Santosh explained in relation to his experience working with predominantly poor patients in a government hospital:

Especially when we are males and we are carrying some tools, they think that we are doctors, they don't know that there is a distinction between doctors and nurses, doctors are this and nurses are this, they don't know... for them, the hospital is just doctors. In the hospital, if you meet someone, that's a doctor ... because each time we pass through a ward, there will be so many people coming behind us saying 'Doctor, doctor please come and see me'.

Consequently, while the various roles, uniforms and titles were not always well understood by the general public, within the nursing and medical corps these hierarchies were deeply ingrained and observed. Senior Consultants were typically referred to as 'Sir' or 'Maam', as were Nursing Superintendents and Nursing Principals. Junior doctors were referred to as 'Dr X (typically their first name) and Nurses as 'Sister' followed by their first name.⁵⁹ Both doctors and nurses used the term 'seniors' to describe those more senior in age and experience within medicine and nursing respectively and 'juniors' to refer to those who were younger or had recently graduated from nursing or medical school. Although some nurses described doctors as their 'seniors', these terms were most often used to describe intra-

⁵⁹ Site 1 had a much smaller intimate set-up, where the Medical Director was known by the more informal Dr X (first name) along with the other doctors at the site.

professional relationships (i.e. those within either nursing or medicine) thus demonstrating the presence of two co-existing hierarchies.

The separate nursing hierarchy has a key function with regard to nurse training and management and is therefore kept distinct from the chain of command within medicine. Nursing management exerted control over nursing administration in order to maintain a distinct separation between the management of nursing and medicine and, in doing so, retain control over the practice of nursing. Nurse supervisors managed the duty roster and leave requests and were also responsible for nurse recruitment, training and discipline. As Walby and Greenwall note, the control of nursing appointments is absolutely fundamental to the notion of nursing as an independent profession (Walby and Greenwall 1994). Nurses therefore fiercely resisted attempts of doctors to interfere in this area, where across the sites (with the exception of the private outpatient clinic) interviews with potential candidates were conducted largely by nursing superintendents and other senior nursing staff. Dr Tandekar, the director of the cardio-thoracic hospital, told me that he 'kept out' of nursing recruitment and was not involved with nurse scheduling and other nursing management issues, which were handled by senior sisters on the wards.

Although doctors did provide guidance and explain medical procedures to nurses in an informal manner, it was generally understood that formal training was to be undertaken within the nursing hierarchy. For example, in the cardio-thoracic hospital, recently recruited junior nurses with no prior cardio-thoracic experience were requested to attend a year long course in cardiology, after which they had to pass an examination in order to make the transition from 'staff nurse intern' to 'staff nurse'. The course was designed and delivered predominantly by nurses, however some modules were taught by other health professionals, such as doctors and nutritionists. Here, the management of nursing training was controlled by nursing management, again with little interference by medical staff. At the other sites, senior nurses were also responsible for training and supervising juniors under their care. This also included handling disciplinary measures involving nurses, such as issuing cautions and dismissal.

Like medicine and the difference in professional authority between junior doctors and consultants, nursing is also characterized by its internal hierarchy and is somewhat militaristic in nature. For junior nurses, a hierarchical relationship with senior nurses typically characterizes their first years of hospital nursing. For example, Prabha and Kumari told me that senior nurses could be 'scary' and that sometimes they would 'run away' if they saw

them for fear of being scolded. Sister Josephine also described having to shout at junior nurses when they made mistakes in patient care. She recalled:

Josephine: Sometimes when they do mistakes and all we shout. We shout at them and after that I become alright. But at the moment I get angry, I shout at them badly.

SJ: What makes you angry?

Josephine: Anger, it's only when they do mistakes with the patient care ... See, if you don't get angry, a few girls are difficult to manage. They will not take you seriously unless you are tough with them, some people. And some people, once or twice in a nice way you can tell them.

As indicated by the extract above, the function of 'being strict' is to establish order and discipline within the nursing corps. For senior nurses, the nursing hierarchy therefore is both necessary and functional to retain control over the practice of their profession and ensure 'quality control' in relation to nursing care. With regard to doctor's interference in nursing management at her hospital, Sister Josephine was very clear:

Josephine: So, if X,Y, Z person (doctors) says 'Why did you give that person (nurse) this patient? Why are you doing that'? Naturally we get angry. And we say 'this is our duty, you don't interfere'.

SJ: And 'they' are the doctors?

Josephine: Yeah doctors. See one question I usually ask them is 'Have they done any mistakes'? If they say 'No', we tell them not to interfere. If they do mistakes, if you find any fault with them, then okay, we will tell them.

There were two different systems of dealing with 'mistakes' on the part of doctors or nurses. Doctors reported pointing out errors in patient care 'on the spot' to the nurse as well as reporting these to nursing management. Dr Bhavan explained how the common practice in his ICU was to write mistakes in an 'issues' book that would be read by each subsequent shift of nurses and doctors on duty. Mistakes made by junior doctors or consultants however, were not pointed out directly by nurses (particularly more junior nurses), but rather taken higher up the nursing chain of command typically to the level of nursing superintendant who would report the mistake to a senior consultant who would then take appropriate action with the doctor concerned. In this respect, while doctors were empowered to intervene directly in nursing care by pointing out errors, nurses were not able to do this directly. Taking the matter higher up through the nursing and medical chains of command was therefore demonstrative of a 'diplomatic' solution to a potential source of inter-professional conflict and was a means to ensure that doctors maintained control over the boundary of medical practice.

Depictions of nursing work

In their interviews, nurses frequently referred to their regular and sustained interaction with patients as a way to demonstrate their knowledge of the medical, psychological and emotional states of individual patients. Given the greater authority of doctors over medical treatment decisions, nurses frequently highlighted an area in which they could demonstrate more professional 'expertise' - namely managing patient's 'feelings' and thus contribute to a more holistic interpretation of 'care'. Talking to patients about personal problems and demonstrating empathy was seen as an important part of nursing, rather than medicine. In this sense, emotional support was firmly located within the nursing boundary of 'care' in the narratives and as such, had an important jurisdictional function.

The importance placed on communication and demonstrating 'empathy' with patients resonates strongly with the practice of 'emotional labour' that has been studied in various settings and seen as an essential part of nursing work (Smith 1992). Examples of emotional labour work with patients that I observed being carried out by nursing staff across the sites included 'surface gestures' that offered comfort such as smiling and taking a patients' hand (Gray and Smith 2009). For the nursing superintendants in particular, 'rounds' involved chatting with patients and asking how they were feeling, in addition to checking charts and consulting with junior doctors about the treatment plan. During one site visit to the private teaching hospital, I accompanied Sister Lily on her rounds of the 'free wards' where we stopped off at various beds to check charts and chat with patients and their relatives. During her rounds of the ICU, this talk took on a different tone, one that was more reassuring and soothing, in which she comforted patients in addition to holding their hands and stroking their hair.

Emotions work appeared to give nurses working across the sites a sense of purpose and was portrayed as a distinct part of the nurse-patient relationship. Emotional labour skills such as 'talking nicely' and 'smiling' were seen by nurses as being important in creating a positive atmosphere on the wards and keeping patients' happy. For example, Vandana, who worked with poor patients on the 'free ward' in her hospital told me:

The poor people are very satisfied because we are talking nicely. Every morning with smiling face we will go the patients, then wish the patients. If educated, means 'Good morning'. If uneducated means 'Namaste'. They are all very happy.

During the interviews, nurses often mentioned engaging in ‘reassuring talk’ which often went beyond the immediate health problems faced by patients to include other problems within the family, such as problems with children, financial difficulties and so on. In this respect, nurses often adopted the work persona of ‘counsellor’ where questions about personal matters within families and households were routinely integrated into nurse-patient communication and were an important part of demonstrating empathy with patients. Vandana explained:

When morning we are coming to the hospital, we will talk to the patients, we will share the problems. We will ask about family matters also. If there is one patient, how many children, are there any problems in your house? We are talking to the patient attenders (relatives) also. That time we will get the family matters also. Some patients are very poor and two or three children are there, now not married. We share the problems.

Talking to patients about their personal problems and in doing so, relieving anxiety, was seen to have high therapeutic value and important for their patients’ recovery. For example, Bhavna, a 29 year old nurse who worked in the surgical ICU told me that talking to the patient was an important part of ‘pain relief’:

Listening to the patient is very important. Then automatically they will get some pain relief no? So, we will talk more to the patient. It will cure some pain and whatever tension and it will come down. So, we have to talk daily to the patient. Best medicine.

Notable differences in the portrayal of the nurse-patient relationship came from OT nurses who deal mainly with the ‘unconscious patient’. In depicting their work, OT nurses often reported feeling a great satisfaction derived from the feeling of ‘saving patient’s lives’. Consequently, they constituted their relationships with patients in different terms and also derived a sense of purpose from working with surgeons and other members of the surgical team in this context. For most nurses however, it was the ‘one on one’ relationship with patients that provided an important sense of professional identity as well as job satisfaction. For example, Sarita, a 37 year old nurse working in the ICU of government hospital told me:

To give you an example, even doctors they do their part of the job, but dealing emotionally and psychologically, being in touch with the patient, interacting with them, interacting with the family, the nurses do it - And being a part of their joys, their sorrows, their aspirations, hope, disappointment, we see on a first hand basis ...

Emotional labour was presented in the accounts both as a core component of nursing care as well as a means through which to portray nursing as a morally worthy profession. For example, a key narrative device frequently used by nurses was to employ vocational language when describing their relationships with patients, particularly the notion of performing a 'service' both to patients and to wider society. For example, Sister Lizzy who worked in a private mission hospital explained:

We are really enjoying our job because we are helping the people. They are really sick and we are doing some service for them and after that they are getting well. And it's really good, I am feeling that it is a good service for the people.

In addition, some nurses told extended nurse-patient 'stories' in which they established themselves as the central character facilitating the care and recovery of critical patients. These stories acted as 'moral accounts' that portrayed the dedication of nurses towards their patients, where nurses regularly went 'beyond' the care expected of them in the function of their duties. Given the importance of Florence Nightingale as a professional role model in India and that the representation of nursing care within the stories has strong associations to the image of the 'Lady with the Lamp' I have called these accounts 'Nightingale Stories'.

'Nightingale stories'

In India, Florence Nightingale is recognized as the pioneer of modern nursing and functions as a professional 'role model' for nurses. In Karnataka, as in other Indian states, a Florence Nightingale awards ceremony is held every year on May 12th, the anniversary of Florence Nightingale's birth with prizes given in various categories.⁶⁰ Nightingale's image is prominently displayed in nursing colleges and at nursing events, and nursing textbooks are often prefaced by the Nightingale Pledge. It was also not uncommon for nurses, particularly older nurses, to refer to the 'Lady with the Lamp' when describing the characteristics nurses should possess - particularly being 'dedicated' and doing nursing work 'with love.' In my interview with Sophie, she highlights how she was touched by the story of Florence Nightingale while still at school:

⁶⁰ These included 'Best South Indian nurse', 'Best retired nurse', 'Best student nurse', 'Best Anglo-Indian nurse and others.

When I was a young girl, before I left school, I made up my mind to be a nurse because, you know, I always er, when we heard about Florence Nightingale in school I was very touched. She was so kind, even to animals when she was small, and then when she grew up she went and helped on the front during the First world, er Crimean war...

Similarly, at the State level nursing conference, a number of speakers emphasized that the values extolled by Florence Nightingale and her devotion to nursing should be exhibited by all Indian nurses. For example, a male speaker told the audience: *'The patient should see that Florence Nightingale is standing in front of me'*. Florence Nightingale then, appears to be a shared cultural icon amongst nurses, and is employed by both male and female members of the profession to refer to the 'ideal nurse'.

The emphasis and importance laid upon serving the poor and sick was often used to explain patient relationships as well as to defend the nature of nurses' work against 'threats' such as a negative public image about the quality of nursing care and hierarchical relationships with doctors. At various points in their narratives, nurses undertook a great deal of discursive work in highlighting the importance of nursing, and how crucial nurses' work is to the survival and recovery of patients. These stories evoke the image of the 'lady with the lamp' particularly as they emphasize the centrality of devotion, dedication and duty to nursing, values that are seen as fundamental to nursing and a cornerstone of Nightingale's legacy.

In some narratives, nurses told extended 'stories' in which they presented themselves as the key agents in patient care. Interestingly, these accounts resembled the 'moral tales' observed by Geoffrey Baruch when interviewing parents of children being treated in a pediatric cardiology unit and a suburban children's hospital. In Baruch's 'moral tales', parents describe the health condition of their child and their interaction with health professionals in a way that demonstrates 'moral adequacy' so as to convey a sense of control regarding the interaction with medical staff and the appearance of fulfilling their parental responsibilities with regard to their child's illness (Baruch 1981). 'Nightingale stories' have an essential vocational theme in which the teller portrays herself as going beyond the 'call of duty' and thus deeply personally committed to their patient's welfare. The following are three notable 'Nightingale stories' told by Sister Meena, Sister Josephine and Sister Sarita.

Meena (59 years, private mission hospital)

One day I enjoyed in my life, that moment was great. Er, one patient was, er recently it happened, one patient was in CCU (coronary care unit). Same duty that day I did also, supervisor duty. At 12.30 my supervisor told me 'one patient is going to die. They are very poor, no money, no attenders (relatives) and the patient is in a critical condition'. And the patient was on ventilator and all parameters were very less, poor condition, poor diagnosis, everything. He already had a heart attack. Three arteries were also blocked. And er, he is very young ... I got a shock or something. He was very young! Nobody is there to take care of them. And everybody is helping, but that poor fellow is going (dying). That lady (his wife) doesn't know anything. She is sitting and crying and one baby is there and one more baby is there at home ... He is critical only and he is almost all gone. No pulse, no urine, nothing. Then in my mind came 'I ought to see that fellow immediately' and so I told my sister 'I will go and see them'. Then I went and saw. Everything is gone, it's like he was gasping. And then I prayed, there I prayed 'God, can you do anything'? I prayed a lot there and I told the staff also, I told them 'if any extra medicine is there means I will give it'. So, I came to my ward and I gave IV fluid, IV extension and tubes, so many things I have given to that patient. At four o'clock I came and everybody is praying for him ... Sisters, all are praying, also a very critical moment. Then four o'clock again I asked 'what is the patient's condition'? and er, really it was like a miracle. She told me 'His BP is maintaining, urine output is draining...saturation, oxygen saturation, everything is going very well'. Really, I was very happy, I was very happy and I went there and I saw him and prayed again! I told the Chaplain ... 'Father, you also please pray for him'. He was also praying and every time he was going there he was also praying. Everybody was praying, continuous prayer. So many prayers and he improved, slowly improved...he was discharged after ten, fifteen days. That made me really happy.

Josephine (37 years, private hospital)

One patient went for a surgery, an aortic valve replacement. See, that patient, initially she was not willing to go for surgery. The family people forced her and got her here - I went and was speaking to her about her surgery, reassuring her. After giving her reassurance when she went to the OT, she wanted to see my face before she took anesthesia. She was just asking me 'will you be there during my surgery'? I said 'Yes, don't worry, we'll all be there'. But as I used to be outside, I wouldn't go to the OT except sometimes. So, when she was asking, I thought that she was like other patients when asking. Finally, she was so serious about it, she told the anesthesiologists Dr Kama and Dr Naidu 'I want to see...' She didn't even know my name! She wanted to see 'the round face' she was telling. So they were asking 'Which sister with the round face'? They were wondering. And then finally Dr Naidu asked 'The one who wears the sari'? and she said 'Yes'. So they called me. I changed my clothes and went inside, removed my mask and showed my face, and then she took anesthesia.

Sarita (37 years, government hospital)

The thing is, we love our jobs. And the feeling of being useful to people, as I said, it is great. Though we may not be appreciated by people who are important to us, but then

when people like the patient's relatives smile, even that weak smile, and that, they may not thank us, but you know they are happy with the care we give. Because they are already overstressed and their emotions are high, they may not, you know, most of the patients here are either in a coma or they are not responding, or there is a little response, you know when there is a little response, the happiness they show. We have had people who come back to us once they get cured, they come back to the normal state. They come back to us, they talk to us, they recognize our voices, they may not see our faces you know. They come back to us and say 'there is the voice I want to meet'. It is so uplifting for us. Like we had a patient, he was there with us for almost six months. The doctors had given up hope but still for the last moment we fight for the life, you know. And the best we can do, we do. And then, we used to talk to him, it's not like you just do your work and go. We talk to the patients, we know that they hear us. So we talk to them, and when they come back they say 'this is the voice'. They don't know our face. They just open their eyes and see and after that they go to recovery ... So they come back saying that this is one particular voice, or this is one voice I want to thank because that was a voice that was comforting. They say 'This is the voice. Sister, thank you so much. You have been instilling so much of hope, courage, talking to us. And you hear so many strange voices around us, and yours is so comforting and soothing'.

The stories above were told by nurses working in critical care and thus revolve around the care of critically ill patients. In these accounts, nurses allude to a privileged knowledge of both the emotional and physical state of their patients, thus establishing themselves as the true custodians of patient care. The stories therefore function as a device in which to make 'sense' of the nurse-patient encounter through a 'public rhetoric' in which nurses can construct a more positively valued social identity (Millward 1995). One explanatory reason why 'Nightingale stories' were found in the narratives of critical care nurses is that, whereas other nurses are able to demonstrate a good emotional connection with patient through emotional labour work, it is more difficult for nurses dealing with the 'unconscious patient' to do so. Consequently, critical care nurses may have used Nightingale stories to reassert the 'closeness' of their relationship with their patients to reaffirm their professional identity as nurses.

The stories are striking in that they function as a narrative device to identify the key actors as nurses and where other professional characters, particularly doctors, are largely absent. A feature of the stories is that nursing care is still provided even after doctors had 'given up all hope' and is symbolic of the perceived medical/nursing boundary in patient care, in which nurses see themselves as adopting a more holistic approach to their patients. The intimacy of nurse-patient relationships is used as a means to establish professional distinctiveness and includes their function as patient advocates in which nurses 'speak' for the

patient with other health professionals and, importantly, represent the patient's interests at all times. Through 'Nightingale stories' therefore, nurses are able to reconstitute a stigmatized identity into one that is based upon commitment, dedication and high moral values.

Summary

Although the relationship between medicine and nursing in the study setting can be described as hierarchical in terms of the enactment of professional power relations between doctors and nurses, nurses were able to demonstrate greater autonomy according to factors such as the institutional environment, the clinical setting of nursing work and through the strength of nurses' relationships with doctors, which was typically influenced by a nurse's age, seniority and perceived 'competence'. These features provided some nurses with more autonomous decision-making power in relation to patient care than their colleagues and often led to instances where nurses could 'cross-over' into medical territory without open inter-professional conflict. While nurses accepted that medicine was the dominant paradigm over treatment decisions, they fiercely resisted any attempt to bring nursing under the purview of medicine and thus the presence of two hierarchies allowed nursing to assert a distinctive identity from medicine.

Some of the nurses interviewed attributed the dominant attitude of doctors to the patriarchal structure of Indian society in which (female) nurses adopted a conciliatory stance in their professional relationships with (male) medical staff. Female nurses were therefore seen as most likely to manifest facets of the traditional 'doctor-nurse' game. This view largely reflects the gendered history of nursing where in India, as in other countries, nursing developed as a female profession that was subsidiary to the 'male' profession of medicine and to a great extent, remains as such. At the same time, as a number of doctors working in Bangalore's hospitals are female, it is likely that variations on the 'female-nurse/male-doctor' relationship may produce different inter-personal relationships between doctors and nurses. In addition, although male nurses were able to demonstrate more camaraderie with male doctors in particular, this was not observed to transcend the traditionally hierarchical relationship between nursing and medicine in the study setting. Age and experience, on the other hand, were found to be much more influential in terms of exhibiting professional autonomy in relationships with medical staff.

Given the medical dominance of doctors in the management of patients, nurses were keen to establish a professional identity that was focused on holistic patient care, and particularly ‘emotional labour work’ which nurses claimed as part of ‘their domain’. The interviews across the sites demonstrated the use of vocational language to present nursing as a morally worthy profession whose members were deeply committed to patient care. At the same time, given the continued social stigma attached to nursing, it was important for respondents to present their own versions of nursing to a non-nurse listener. Depictions of nursing demonstrated an emphasis on ‘ideal type’ nursing behavior (such as being dedicated and showing empathy) where this was viewed by nurses as crucial towards developing a positive ‘image’ of nursing for a public audience. ‘Nightingale stories’ therefore functioned as an important narrative device in which to demonstrate the value of nursing to patient care and in doing so, emphasized nurses’ distinct professional identity.

In the following chapter, we shall examine how at a collective level, the nursing profession is also developing strategies towards addressing threats to the social identity of its members through its efforts to achieve collective social mobility, and thus, greater professional status for nurses in 21st century India.

Chapter 6

“Convince your patients and you will convince society”: collective social mobility and the professional project of Indian nursing

Professionalizing strategies have been described as having at their core a movement towards achieving collective social mobility for a profession's members (Johnson 1972; Larson 1977; Macdonald 1995). As discussed in earlier chapters, previous research on Indian nurses has demonstrated that nursing offers the possibility for individual social mobility for women in Kerala via the prospects of a 'good marriage' through the possession of a nursing qualification and the potential for overseas employment (Percot 2005; Nair and Percot 2006). These studies stop short of examining the effects of migration on the collective social mobility of Indian nurses as an occupational group as they are concerned mainly with the social status of nurses as women in Kerala society. As we saw in Chapter 4, migration provides nurses with the opportunity for career mobility where nurses who leave India for overseas employment are typically able to command higher salaries and obtain more senior positions in nursing education and in hospital nursing upon their return.⁶¹ In addition, this study found that the perceived demand for Indian nurses abroad was viewed by many nursing leaders⁶² in India as an opportunity to secure greater social and economic rewards for nurses as a collective group and consequently, migration has become an important professional 'asset' to advance the collective interests of the nursing profession in India.

Given the historical association between nursing and low status work that continues to endure in contemporary India, professionalizing strategies promoted by nursing's leaders focus on constructing a positive public image of nurses with the aim of achieving greater social and political legitimacy. As this chapter will reveal, while the central aim of professionalizing strategies is to attain vertical social mobility for Indian nurses, dilemmas were evident regarding the future direction of nursing in India. For example, while almost all nurses supported the notion of gaining a professional status in which nurses occupied a position as doctors' 'peers' rather than as their subordinates, there was evidence of a striking tension in the desired professional image of Indian nurses. This tension is characterized by

⁶¹ For example, a number of the nursing principals and nursing superintendents interviewed as part of this research were return migrants.

⁶² By the 'profession's leaders' I refer to nurses active in nursing associations in India, nursing superintendents and heads of nursing educational institutions, many of whom spoke at the State level nursing conference and whom I interviewed individually during the course of the fieldwork.

two potential professional identities. One identity sees Indian nurses as highly specialized in clinical disciplines as a means through which to gain expert knowledge and exert increased autonomy over the direction of patient care. The other identity sees nurses return to the notion of nurses as 'bedside' care giver and was thus characterized by a reemphasis on essential nursing skills. This divergence can be seen as contributing to a 'fractured collective identity' in which different visions are presented as 'the way forward' for Indian nursing. In addition, important fissures in notions of professional identity were found through diverging accounts of the professional image attributed to 'private' and 'government' nurses and in the inter-generational tensions between the perspectives of older nurses who used 'rhetorics of nostalgia' to describe a golden age of nursing and a return to traditional values, and younger nurses who were keen to demonstrate a modern 'career'.

In this chapter, I discuss how the social identity of Indian nurses has important repercussions for the collective professional identity of nurses in India, where professionalizing strategies promoted at the level of the profession are focused on reconstructing nurses' social identity through the presentation of a professional public image. Finally, the chapter highlights the importance of Florence Nightingale as a collective 'icon' for Indian nurses and a symbolic means through which the profession's leaders seek to generate a sense of unity among the members of an increasingly divergent profession.

A negative public image: social identity and threats to professional status

In his discussion of the 'backward classes' and the new social order in Indian society, anthropologist Andre Beteille points out that social superiority in India is not defined so much in terms of wealth as it is in terms of 'purity' (Beteille 1992). Consequently, it is the stigma of 'pollution' rather than poverty that has historically defined social stratification within Indian society (Beteille 1992; Somjee 1991). Although nurses in the study setting came from different castes and religions, nurses as an occupational group continue to be associated with historical prejudices that view nursing work as low status and socially undesirable, unlike medicine. As we have seen in the introductory chapter of this thesis, medical doctors are aligned with the Brahminical tradition of 'healers' and thus, largely protected from the label of 'dirty work' (Somjee 1991). In addition, the sexualization of nursing work through the physical contact between nurses and male patients and the corresponding association between

nurses and women of ill repute has contributed to a 'double stigma' for nurses in the sub-continent (George 2005; Hadley et al. 2007).

Across the sites, the low public image of nurses in India was seen as a major threat to achieving both social and professional recognition for members of the nursing profession. The following anecdote relayed by a conference speaker illustrates how the occupational title of 'nurse' continues to denote a somewhat stigmatized identity:

I was on a train and I was chatting with a man who then asked me for my visiting card. He looked at my card and asked 'Are you from X (well known hospital in Bangalore)?' I said 'Yes'. He said 'Are you a doctor? What is your speciality'? I said 'I am a PhD, I am a nurse'. 'Oh (pause) a nurse' he said. He looked like I had just pricked his balloon.

There was a striking tension in the accounts in which nurses simultaneously recognized an improvement in the image of nursing due to its employment scope in India and abroad, but also acknowledged that nursing had still not completely shed its association with menial and 'polluting' work. Such tensions also emerged in nurses' depictions of their relationships with patients. While nurses predominantly highlighted positive experiences with patients, negative patient encounters were most often linked to behaviours reinforcing perceptions of nurses' social inferiority. For example, some nurses described being treated 'like servants' or complained that some patients looked at them 'in a vulgar way'. Others used the low status given to nursing work to describe situations where patients deferred medical and treatment related questions to doctors. As Miriam explained:

Because in the Indian set-up, nurses are a little down like...and doctors are a little up like. In our Indian situation, we will tell one patient something, he will tell 'We will ask the doctor.' So that idea is with them. So they are not calculating how the nurses are caring for us as a nursing care, and how the doctor is caring as a like, treatment based. They are not evaluating, because they are always thinking that the doctor person is up. That is our society's culture.

Similarly, Shalini, who worked in the private outpatient clinic, told me:

the public is not giving that much value for a nurse. See, if we tell the patient 'this is the problem, relax, the doctor will come and examine you. We are checking your vitals. Everything is normal, don't worry'. Sometimes the patients won't listen to us. 'Where is the doctor'? When a nurse comes to attend to them, they are not happy. 'Call the doctor, let the doctor come'.

As has been reported in other contexts, the media was seen to promote stereotypical images of nurses (e.g. see discussion on images of nurses in Salvage 1985). Many nurses felt that their problematic social identity was bolstered by the media, particularly through film and television, which frequently showed nurses in an 'unprofessional' light and reinforced the cultural stigma of nurses as 'fallen women'. In her description of a recent commercial and Bollywood film, Sister Deidre recounted:

Deidre: Then we had one incident with virgin mobiles... They had an advertisement where they showed nurses in a poor light. There was a patient lying on the bed and he had fractured his hands and legs and his mobile was ringing. So, the nurse comes in and she wants to help the patient get the mobile, so she puts her hands underneath the bedclothes and starts to feel around. And you know, he is so excited about her touch on his body that he gets a high. So, that is the type of image that is depicted about a nurse. When we heard about this, immediately we sent, you know during the nursing forum, we sent an sms. Nearly 500 nurses sent an sms and that advertisement was withdrawn.

SJ: It was a TV spot?

Deidre: It was a TV spot shown across India. What a bad image for nurses! We were able to remove that TV advertisement from the channel. That is why, you know, people think of nurses as really cheap. Then there was one movie that depicted nurses in skinny nursing uniforms and prancing around with the hero. The clip of that in the movie was removed. It was done by irresponsible people in Bollywood and they apologized to nurses. We made a big noise about that and it was removed.

In the interviews with nurses, the relaying of concerns around a poor public image exposed deep divisions in the construction of a collective professional identity. A notable feature of the narratives of private hospital nurses was the attribution of 'blame' to government nurses whose behaviour was seen to buttress negative perceptions. As discussed in the previous chapter, nurses across the settings undertook a great deal of narrative work to present themselves as members of a morally worthy profession in which their commitment to patient care is paramount. The association with corruption and poor levels of care tarnished the image of government nurses and consequently all nurses, whether government or private sought to distance themselves from the popular stereotype of the 'government nurse'. At the same time, the 'othering' of government nurses by their private hospital counterparts presented the profession's image of itself as deeply divided with the identities of hospital nurses seen as closely affiliated with the institutional setting of work rather than with the

profession as a whole. For nursing's leaders however, the low public image of nursing presented nurses with an important collective threat to claims for greater professional status. Consequently, achieving greater social and professional recognition was promoted through the notion of building a strong collective identity for all nurses and an elevated image of nursing for a public audience. Professionalizing strategies put forward by nursing's leaders therefore concentrated upon improving the image of nurses in the hospital environment, where this was perceived to have a 'knock on' effect on the perception of nurses in wider Indian society. As a speaker at the state nursing conference urged his fellow nurses "*Convince your patients and you will convince society*"!

Presenting a professional 'image'

In his study of health visitors in the United Kingdom, Robert Dingwall describes how students began to adopt a repertoire of behaviours that presented a 'professional' image to clients, and avoided behaviours viewed by gatekeepers to health visiting (tutors and community health staff) as 'unprofessional':

Clare said that she had been criticised by her assessor for not looking elegant enough and for leaning on the table while talking. She had been told that this was 'unprofessional'. Alex said Mike was also pulled up for that. (Dingwall 1977: 129)

Dingwall's study suggests that the emphasis on behaviour while providing a 'professional' service is purposefully undertaken so as to convey the image that both the service and its practitioners are 'special' and thus distinct from other occupational groups and members of the public (Macdonald 1995; Dingwall 1977). Health visitors thus 'accomplished profession' through the careful management of their behaviour vis a vis their clients (Dingwall 1977).

A similar phenomenon was observed in the study setting, in which nursing superintendents and nursing faculty frequently reminded students and junior nurses to adopt a professional persona at all times within the hospital as a way to emphasize the inherent 'respectability' of nurses and of nursing work. Like Dingwall's health visitors, an emphasis was placed by nursing faculty on the presentation of nursing students and junior nurses. As nurses in the study setting wore uniforms, less emphasis was placed on appropriate dress and more on adopting appropriate mannerisms within the walls of the hospital (e.g. "stand straight", "don't gossip", "greet patients") and can be considered as part of the attempt by nursing staff to instil a code of professional conduct on neophytes during the early stages of

their training. Self-presentation was promoted as an important part of projecting a professional image where the public within the hospital was a conduit towards influencing public opinion outside the hospital.

Various ways to present a professional persona were a key feature of the nursing conference which served as a professional inventory and pep talk for participants. In addition to behaving in a smart and professional manner, adopting a professional persona included the projection of an empowered self in relationships with hospital staff and patients through 'learning how to say no', 'being confident' and 'speaking clearly.' The following is an extract from statements recorded in my field notes during a presentation on 'assertive skills':

Speaker: Show assertive body language, have a firm handshake!
Stand straight! Be direct and clear- Don't beat about the bush!
Use a broken record technique- make your point over and over
Use 'I' statements: always tell what you want to tell to others, for example "I feel, I want".

Speaking in English was also presented as a means through which to close the social divide between doctors and nurses and present nurses as educated and thus, knowledgeable. As one speaker addressed the audience, and particularly the nursing students present:

You girls need to be motivated. You girls need to be assertive. If the doctor's notes are illegible and the signature is not clear, you must say! If you are assertive for the right thing there is no harm ... You must know how to talk, and where to talk. Stop talking in your regional languages. Talk in English! If someone passes you, such as a doctor, and you are talking in your local tongue, he or she will say 'What is this person talking about'! But if you talk in English, they will listen and take notice.

Student nurses were encouraged to speak in English to their hospital colleagues and were frequently reprimanded for conversing in the vernacular which was seen to present a more 'local' identity to patients and hospital staff rather than that of an assertive 'global' nurse. In Bangalore, as in other large Indian cities, the effects of globalization have underlined the importance of English as a common professional medium of communication.⁶³ The popularity of English education has increased significantly in India over the last ten years including among poorer segments of the population who view the prospects of English education as allowing their children to participate in 'new economy jobs' such as in the IT

⁶³ For example, the increased popularity for 'outsourcing' services to India by countries like the United States is attributed to the large pool of English speaking professionals and the lower production and labour costs (Nicholson and Sahay 2001).

industry (*Times of India*, January 16 2010). The ubiquitous IT workers in Bangalore for example, have adopted English as their lingua franca and consequently, there were suggestions that nursing leaders were keen to emulate the practices of this globalized group of new professionals in promoting nursing as a modern, Westernized project.

The presentation of a professional ‘persona’ also included the display of skills in emotional labour. Nursing leaders repeatedly referred to the existential and vocational qualities expected of the ‘ideal nurse’, such as demonstrating a ‘caring’ and ‘dedicated’ attitude with patients through smiling, listening to patients’ concerns and showing empathy. Conversations with older nurses, in particular, indicated their concern with the perceived lack of a ‘caring attitude’ among junior nurses, who were criticized for their lack of attention to ‘detail’, such as fetching extra pillows for elderly patients, or for not willingly working overtime to assist with a critical patient.

An emphasis on caring skills in carrying out nursing functions was depicted as key to acting in a ‘professional manner’ as a nurse. At public nursing events, Florence Nightingale was frequently invoked as a role model for values that all nurses should aspire to (“*patients should see that Florence Nightingale is standing in front of me*”), where embodying a vocational attitude was promoted as integral to the notion of being a ‘good nurse’. As will be discussed in the following sections, the internalization of nursing ‘values’ is part of the process of socialization into nursing culture and considered to be a fundamental part of nursing knowledge and education. The perception of an erosion of vocational values seen as fundamental to the project of nursing was a live issue, where older nurses in particular felt strongly that younger generations of nurses no longer looked upon nursing as a ‘calling’ but a ‘career’.

Achieving occupational closure: regaining control over nursing knowledge

For most sociologists writing about the professions, the possession of ‘esoteric’ knowledge is the foundation upon which professional claims are built (Jackson 1970; Elliott 1972; Macdonald 1995; Dingwall 2009). Through knowledge, occupations are able to demonstrate ‘credentials’ and achieve social distance with the lay public through claims towards ‘expertise’. Maintaining control over knowledge is therefore a critical part of a professional project where, as Elliott aptly points out “*an occupation with pretensions to professional status cannot afford to be seen as a refuge for the unqualified*” (Elliott 1972:

112). In her work on the 'politics of nursing knowledge', Anne Marie Rafferty describes how nursing education is the "*vector and vehicle of occupational culture and closure*" (Rafferty 1996: 3). Nursing education has also been described as the main mechanism through which nursing values are conveyed to students through its importance as the site of socialization into nursing culture (Salvage 1985; Melia 1987; Rafferty 1996; Maben et al. 2007).

The issue of nursing education was one that occupied an important place in discourses around professionalization. Here, emphasis was placed both on the content of nursing curricula as well as regaining authority over the delivery of nursing education, both of which have implications for ensuring occupational closure. In their interviews, nurses frequently reported learning key skills in nursing, such as how to communicate with patients 'on the job' and acquiring increased expertise in this area over time. Therefore, a theme that was raised frequently by nursing leaders was that these 'soft skills' needed to be greatly improved among nursing graduates through, for example, role playing with mock patients as part of nursing education. Although the GNM and BSc nursing curricula includes training in health promotion where students often undertake a rural community posting, nursing examinations are geared towards clinical knowledge with less emphasis on formally testing nurses' communication skills with patients. It appears therefore that learning in this area is the initiative of individual nursing principals and faculty. The Principal of one of the nursing colleges visited was particularly concerned about a lack of training in patient communication around treatment and care, and informed me that these workshops were part of a pedagogic approach to improve confidence among nursing students and encourage them to talk more assertively with patients and other health staff. In other words, they had a dual purpose of training students in relationship building with patients, as well as to improve the image of nurses in the hospital setting through better overall communication skills. Other nursing leaders also expressed concern that recent nurse graduates were often poor in spoken English and this impeded their ability effectively in hospital settings in which English was the working language.

The lack of adequate teaching on developing effective communication as part of nursing practice is framed within the general critique of a disconnect between theory and practice in nursing in India. An important part of this critique is related to the limited amounts of time student nurses spend in hospitals, especially where nursing colleges are not attached to a clinical facility and consequently outsource clinical training to various hospitals. In these cases, opportunities for sustained nurse-patient interaction are limited with most nursing

education confined to classroom teaching. Dr Modi, the medical director of an outpatient clinic, captured these lacunae in training while explaining what she looked for when hiring nurses to staff her clinic:

See, if you are an outpatient, you need someone who is pleasant, talks the patient through (the procedure), because it is not very, it is not intensive care. So 'I am going to give you an IV line, there is going to be a prick etc' and talk you through it, and communicate ... You know, really what we look for here is some skill, but more the ability to communicate and do a good IV fast. Not poke four or five times. And do an IM (intramuscular injection) without getting into the peroneal nerve or something ... In the hospital you are looking for nurses who have the ability to learn really intense skills in terms of putting in an NG (nasogastric tube), putting an IV line and so on, but also really the communication skills also ... They are not even really taught communication skills. There are no mock sessions like 'What do you do in this situation'? ... These skills are not taught in India.

In the Indian setting, diminishing control by the profession's members over nursing knowledge has not only introduced the problem of occupational closure through 'imposters' holding bogus nursing qualifications but through the reporting of such incidents in the media, contributes to undermining public confidence in the integrity of nursing education. Exposés of 'fake' nursing institutions that exist on paper and deceive students who unknowingly apply to them and pay tuition, fees or those that have not received proper accreditation from the state and national nursing councils, have appeared with uncomfortable frequency over the last few years: 'Nine nursing colleges dupe govt' (*The Times of India*, 27th March 2007) and 'Fake nursing colleges thrive for decades' (*The Times of India*, 24th April 2006) are two examples of recent articles in the Indian press. The interview and conference data revealed that in addition to concerns around the educational 'racket' of nursing, there were a number of concerns around the quality of nursing education particularly in privately run institutions.

Since the early 1990s, there has been a large increase in the number of private nursing schools and colleges in Bangalore offering GNM and BSc nursing courses.⁶⁴ The development of private nursing facilities came about largely to meet the demand for nurses both domestically and abroad, particularly in countries such as the United States that were reporting a large shortfall in their nursing workforce. The Karnataka state government encouraged the expansion of private schools and colleges and opened up the possibility of ownership to any individual who possessed sufficient start up capital and was able to meet the infrastructural and faculty requirements set by the Indian Nursing Council (INC) and its state

⁶⁴ See table 5 in the Appendices.

level body, the Karnataka Nursing Council (KNC). The potential for diminished control over nursing education soon became an issue of professional concern following reports of mismanagement, fraud and insufficient facilities in some private institutions. This resulted in the tightening of controls by the KNC and the closure of a number of institutions. While many private nursing schools and colleges in Karnataka do meet the standards required by the national and state level nursing councils, the opening up of nursing education to include ownership by 'outsiders' (those with neither medical or nursing qualifications) has come to be seen as something of a 'pandora's box' raising concerns around the ethos of nursing culture transmitted within these institutions and the quality of education provided.

The 'problem' of nursing education was raised frequently in the interviews and described by many nurses as a 'business'. Of particular concern was the lack of adequate infrastructure and facilities in a number of private nursing schools and colleges in Karnataka, and particularly in Bangalore. During my trips around the city, I observed that a few institutions appeared to only occupy one or two floors of a building and thus did not appear to have the necessary facilities for learning. Malika, a nurse from Kerala, had similar thoughts:

When I got married and after when I came with my husband here, I was travelling in a bus. I saw that on the first floor that had written 'college of nursing'. I thought 'Only this much space is available for a college of nursing? How will they manage like that'? Then my mother-in-law who is from here, she told me 'It is like that here. These nursing colleges will only send their students to hospitals for 7 days in a year'. That is too little.

Unlike government and mission nursing colleges that are attached to their respective hospitals, many private nursing institutions are 'stand alone' and not attached to a clinical facility. Consequently, students who train in nursing institutions that are part of larger government and mission hospitals are considered to be much better prepared for life in the hospital than private nursing students, as they are typically sent to the wards as early as their first year of nursing training. So that GNM and BSc students are able to satisfy clinical training requirements set out by the INC, private institutions with no clinical facilities pay individual hospitals to send their students for training. Students in many private colleges are therefore sent by bus to various hospitals around the city. In order to cut costs, a number of institutions have reportedly reduced the time spent on clinical rotations for students and consequently, do not meet INC requirements. In such institutions, learning has become predominantly classroom based.

Concerns over falling standards in learning were found to have generated a diminished sense of trust in nursing education among hospitals in Bangalore. Nursing superintendents described how many student nurses had very little prior exposure to clinical practice and therefore required closer supervision by senior staff. Most hospitals now implement their own training and assessment periods (ranging from 3 months to 2 years) followed by an in-house exam before students are officially recruited as staff. In addition, some of the larger corporate hospitals have also started their own nursing training programmes after which time graduate nurses are employed for a 'bond period' of up to two years. Nursing superintendents described this training period as a time in which the clinical skills of nursing students would be 'brought up to scratch' and students could be familiarized with the institutional culture of the hospital. In this sense, the training and assessments being undertaken in hospitals emulates the 'old system' of nurse education in India in which learning was undertaken exclusively within the hospital environment. Thus, in addition to reasserting professional control over nursing knowledge, the training period within the hospital is viewed as the key means through which students are socialized into nursing culture.

Although senior, experienced nurses were found to exert more professional autonomy than more junior nurses, 'experiential' knowledge is typically awarded less value than 'credentialed' knowledge, and it is on the grounds of the latter that professional claims are usually made (Macdonald 1995; Elliott 1972). The importance of professional credentials was reiterated by nurses working in hospital settings. When asked for their views on ways to improve nursing, almost all nurses interviewed highlighted the importance of further education following nurse registration. Nurses frequently complained about the lack of opportunities for continued learning and the difficulty of pursuing additional nursing qualifications as these typically entailed 'taking time off' and consequently, was not feasible for many nurses particularly in private settings.⁶⁵ In addition, nurses working in both public and private institutional settings highlighted the lack of in-service educational programmes as a key barrier towards improving nurses' knowledge and clinical skills. Some nurses alluded to a state of knowledge 'stagnancy' in which they felt ill-equipped to deal with transformations in medical knowledge and health technology compared with medical doctors, whose skills and knowledge were seen as constantly evolving. Unlike in medicine, further training of nurses is frequently an initiative of individual hospitals and not a mandatory requirement. As Sarita explained:

⁶⁵ Nurses working in government institutions are entitled to a study 'deputation' to pursue further degrees in nursing. Selection of suitable candidates typically follows a competitive process.

You know, in the medical field every four months, five months there is a new technology and people who are teaching us are not in touch with that. So, they are teaching something that has passed already ... For doctors ... they keep upgrading because they constantly have to deal with the patients. But ours, it becomes sometimes like a sort of mechanical job ... You might be highly intelligent but if you are not in touch, you tend to forget. So upgrading skills is really important ... So, once in five years I feel that there should be a course on a scheduled basis.

As suggested by Sarita, being bypassed by developments in medicine and nursing and becoming 'mechanical' introduces the risk of 'de-skilling', in which nursing functions could potentially be downgraded by hospital management to 'basic care' tasks and distributed to other hospital employees. Counteracting the threat of 'de-skilling' (and thus the threat to occupational closure) is key to the survival of a professional project such as nursing and consequently, revitalizing nursing knowledge is a means through which to revitalize nursing's claim to professional expertise.

In order to demonstrate high levels of knowledge and expertise in nursing practice and solidify nursing's jurisdictional claims, nursing faculty in particular emphasized the importance of 'evidence-based nursing'. Evidence-based nursing was perceived as a way to legitimize nursing's claims to a privileged set of knowledge independent from medicine and to promote a knowledge 'partnership' between doctors and nurses. In addition to the prospects of a more egalitarian relationship with doctors, expert knowledge and skills could also be demonstrated in nurses' interactions with patients, thus improving the public's view of nurses. As one speaker at the nursing conference told the audience: "*When knowledgeable, accountable nurses are by the bedside, then patients will notice the difference*". Students were therefore encouraged to read both international and Indian nursing journals as part of their nursing education and to think about the relevance of the research findings to daily practice. Another nurse emphatically stated:

If every nurse puts into practice one recommendation from clinical research from a journal there will be a great effect...make change permanent!

Here, a strong emphasis was placed by teaching faculty on building up a body of nursing research relevant to the Indian context. The importance of acquiring a body of 'local' knowledge and expertise was related to the general critique by nurse academics of the over reliance in Indian nursing on theories and concepts developed predominantly in Western countries, particularly the United States and the United Kingdom. These were not seen as

completely relevant to the Indian scenario in which nurses were expected to be aware of the implications of social issues such as poverty, illiteracy and social exclusion upon health outcomes. In addition to knowledge of a broad range of health conditions, including infectious diseases (such as Tuberculosis, Polio, Malaria, HIV/AIDS and other sexually transmitted infections) and chronic 'lifestyle' diseases that are increasingly changing India's epidemiological profile (such as diabetes, heart disease and cancers), nursing associations and the Indian Ministry of Health frequently emphasize attention to nationally relevant public health issues such as high levels of maternal mortality, poverty and malnutrition, as well as social problems such as alcoholism, drug use and gender based violence. In highlighting the importance of developing nationally relevant nursing research and practice, the Principal of one nursing college in Bangalore told the audience:

I do not allow my students to copy models from textbooks developed by Americans. I make my students develop their own conceptual frameworks.

Both global and local knowledge of health scenarios was seen as essential in order to respond to India's health challenges and to address the social and health problems faced by the urban and rural poor. Nursing leaders were keen to bolster nurses' professional role as intermediaries between the formal health system and the community through responding visibly and effectively to the health needs of local communities. Nursing colleges frequently hold regular 'health fairs' and 'health days' in the community where students present information about various health and social issues. Some of the city's hospitals also conduct 'village camps' where medical and nursing staff provide diagnostic and treatment services in rural areas. In addition, the Indian Nursing Council has recently announced plans to begin training of 'nurse practitioners' in midwifery who will be predominantly located in rural areas, where these nurses will have a number of independent responsibilities in managing maternal health services and treating patients.

In this respect, building up a body of knowledge that integrates global and local nursing theory and practice was promoted as a way to demonstrate the competency of Indian nurses as both global and local practitioners. However, the capacity to pursue graduate degree programmes in nursing to generate nursing research is currently limited across the country. Although there are plans by the Indian Nursing Council to expand PhD nursing education further in India, at the time of this research, only six academic centres offered an MPhil/PhD in Nursing. One of these centres is in Bangalore with another university in Bangalore

expected to initiate an MPhil/PhD Nursing programme. In addition to creating a pool of nurse scholars to expand a theoretical and empirical base for nursing practice in India, the proposed expansion of doctoral programmes is also to address an acute shortage of nursing faculty in under-graduate and post-graduate nursing programmes. Discussions with nursing principals indicated the difficulty in recruiting nurses with MSc and PhD qualifications to nursing education, particularly as highly qualified nurses frequently elect to seek overseas employment. The shortage of nurse academics in India therefore presents both a challenge to developing expert knowledge, but also to encouraging the academic mentorship of younger nurses interested in pursuing a career in nursing research.

In addition to furthering evidence-based nursing in India, nursing faculty also emphasized the importance of information technology and its integration into nursing education in order to claim technology as part of modern nursing practice. For example, 'computer literate' nurses would be able to manage electronic patient information, access online databases and libraries for information on relevant topics to patient care, engage in 'e learning' courses to update their knowledge and importantly, interact with one another through virtual discussion forums. They would also be able to position themselves within new e-health initiatives emerging in India, such as 'telemedicine' programmes being introduced in some urban hospitals to improve access of the rural poor to medical treatment.⁶⁶ In this respect, the expansion of IT technology in health care presented nurses with an opportunity to incorporate new techniques and expertise into the realm of nursing care and reassert their position as skilled, knowledgeable and efficient health care providers.

Migration: a professionalizing strategy for nursing?

A feature of globalization is that societies have become increasingly heterogeneous, mobile and internationalized (Urry 2000; Ohnmacht et al. 2009). The study of 'mobilities' in contemporary sociology consequently reflects transformations in the social, economic and political fabric of societies raised by the movements of people, goods, information and technology across geographical space in ever decreasing amounts of time (Urry 2010). International nurse migration is viewed as a visible and important example of female mobility (Sharpe 2001; Kingma 2006). Studies of migrant nurses have captured a number of key

⁶⁶ Telemedicine brings the possibility of exchanging medical information via interactive audiovisual media. In this way, medical consultations and examinations are able to be carried out remotely.

factors underlying nurse migration and the reasons underlying the pursuit of an international career in nursing (Kingma 2006; Buchan et al. 2005). Within this literature, relatively little attention has been paid to the function of migration to the *professional project* of nursing.

Data from this study presents evidence of a dual discourse around the phenomenon of international nurse migration from India. On one hand, the migration of Indian nurses to countries overseas reflects the ‘brain drain’ of skilled health workers, where a workforce ‘crisis’ has been reported globally, by a range of low, middle and high-income countries, including India (WHO 2006; JLI 2004). On the other, migration offers opportunities for collective social mobility and thus functions as a key professionalizing strategy.

In international public health literature, the workforce crisis is mainly attributed to shortages of skilled health professionals such as physicians, nurses, midwives and public health practitioners but also includes challenges such as skills imbalances, maldistribution of health workers, poor work environments and weak health infrastructure (WHO 2006; JLI 2004; Narasimhan et al. 2004). Although health worker migration is not a new phenomenon and accounts for only a small proportion of skilled labour migration globally, the health care ‘brain drain’ has captured public attention and is portrayed as a major contributing factor to staffing difficulties particularly in resource constrained settings.⁶⁷ This is in large part due to the impact of high burden diseases such as AIDS and tuberculosis on the health of populations, including the health workforce, and the effects that the migration of skilled health personnel has on the ability of countries to provide treatment and care (Figueroa-Munoz et al. 2005; Marchal et al. 2005; USAID 2003). It is also due to the ethical, moral and emotive issues raised by the movement of people from countries where they are greatly needed to generally healthier, better off nations that have more resources available to meet their health care needs domestically (McElmurry et al. 2006). Doctors and nurses in particular are seen as essential human resources for health and their potential migration represents an important threat to governments in managing the provision of health care.

In Bangalore, the attractiveness of overseas employment was attributed to problems of retention in hospitals in the city and did pose logistical difficulties for nursing superintendents due to high rates of staff turnover in some hospitals. The attractiveness of becoming an international migrant nurse also presented an important challenge to nursing

⁶⁷ For example, in 2004, the World Health Organization Secretariat submitted a report on the *Recruitment of Health Workers from the Developing World* to the Executive Board of the WHO and made a number of policy recommendations to both source and destination countries, such as devising country specific strategies, implementing Codes of Practice for recruitment and other measures. In addition, in 2006, the WHO focused its annual World Health Report on the Health Workforce.

principals of Bangalore's numerous nursing educational institutions who often struggled to find MSc and PhD nursing staff to teach courses and supervise students. Despite these constraints, migration was overwhelmingly depicted by nurses as an important social and economic 'asset' for the profession.

For nursing leaders, migration provided clear 'evidence' of the 'competency' of the Indian nurse. A sense of national pride was evident in some nurses' accounts, in which migration was viewed as demonstrative of the demand for Indian nurses through the recognition of their skills outside India's borders. Consequently, emphasis was placed by nursing's leaders on capitalizing upon the vision of the 'global Indian nurse'. As one nurse speaker noted "*We need to tone up our skills to present a more accomplished health worker to the world*". Similarly, the registrar of the University of Health Sciences added "*The most important thing is that our nursing profession should be recognized by developed countries.*" The perception of nurse migration as a positive development for Indian nursing was also supported by the presence of a Bangalore-based recruitment agency throughout the state level nursing conference. The recruitment agency set up an information stand within the main conference hall, and their representatives gave a presentation to the audience on opportunities for nurse migration particularly to the United States.

Furthermore, migration was viewed as a key means to improve the professional and social standing of nurses in India. As has been found in other studies that have examined the 'push' and 'pull' factors behind health worker migration (Dovlo 2005; USAID 2003; McCourt and Awases 2007, Alonso-Garbayo and Maben 2009), low salaries, poor working conditions, burn out and a perceived lack of career opportunities were seen as contextual factors that push Indian nurses towards employment in foreign hospitals. The low salary of Indian nurses was frequently raised as an issue of concern, where the pay of nurses in some hospitals was seen as equivalent to the pay of 'unskilled' workers and considered to be lower than that of other government employees. For example, 'drivers' in the city of Bangalore were seen as earning a higher salary at approximately 8,000 Rs a month than many entry level staff nurses, whose earnings varied between 5,000-8,000 Rs per month. Other institutional concerns considered to be frequently neglected by the administration of many of the city's hospitals included heavy workloads, long shifts, lack of childcare facilities and properly equipped nurses' rooms. Some of these concerns were also picked up by Dr Modi, who expressed her support for increased benefits to nursing staff as a way to encourage retention of nurses:

Dr Modi: Frankly I think that migration for nurses has been fantastic. Because they can, right? There is at least some pressure here to treat them more decently. If you had an over supply of nurses, oh my god, I can't even imagine their life. Like, if you had more nurses than you had jobs, they would be getting paid 2000 rupees a month. It's pure economics in that sense. Now because they can leave they have options – 'Okay, you won't treat me well, I'll go to the Gulf, I'll go here, whatever. I'll go to the next hospital down the road'. So, the hospital will be saying 'Uh-oh, I had better do something'. And at least in our hospital, their salary has gone up by 2,000 rupees extra a month. They are getting some dinner, an egg at night and a cup of coffee at midnight. They do the night shift and they (refers to former hospital) didn't give them dinner and they didn't give them breakfast so these girls had to cook their food and bring it in for the night shift. Then they get out in the morning, go home and cook their breakfast and then sleep.

SJ: This is at (name of hospital)?

Dr Modi: Yeah, then they get up and cook their dinner and bring it in, only to find that the gas is not there. So, we were like 'Just give them dinner, free dinner and free breakfast, just some little things like that'. And now that there is a shortage of the skilled ones, the hospitals are saying 'Okay, Okay, what can we do'? They are waking up.

As this extract suggests, the open support to migration from nursing leaders in the study setting, strongly indicated that at the political level, migration functions as a means to develop a collective 'bargaining tool' for nurses with which to argue for important changes to their salary and working conditions in Indian hospitals. Nursing principals such as Professor Nande felt that nurse migration was 'required' in order to raise the profile of nurses within India. This sentiment was captured by a speaker at the nursing conference who passionately told the audience: "*let India be empty of nurses and then they will acknowledge us*"! Just as migration offers the prospect of individual social and economic mobility for migrating nurses, it is also a strategy towards achieving collective social mobility and consequently, actively encouraged by many in the profession.

Tensions in the vision of modern Indian nursing

While there was agreement on the importance of strategizing towards a greater professional status for nurses, a striking feature of the data was the divergence in the conceptualization of a collective 'vision' of nursing in India. In many ways, the debate within nursing in India echoes the debate within nursing in other contexts in which a series of

professional dilemmas are posed by the preference for increased specialization and educational qualifications in some quarters and the critique, in others, that these trends are driving nurses further away from the patient and have become a threat to occupational closure (Wolinsky 1980; Davies 1995; Nelson et al. 2002). In the study setting, this debate occurred predominantly at the level of the profession's leaders and, as will be discussed, a divergence was found between these concerns and the perceptions of nurses working in hospital settings.

During the nursing conference, a presentation was given entitled '*Who moved my nurse away?*' in which the speaker asked the audience the question '*Why do youngsters after 1 or 2 years experience move to further qualifications and away from the bedside?*' The presentation reflects a strong perspective within the nursing community that views with dismay a growing trend among the emerging generation of nursing students to reject bedside nursing in favour of a career in specialized clinical areas, in hospital administration and through pursuing further education. 'Moving away' from the bedside is seen as undermining the traditional role of nurses to provide holistic care to patients through general nursing. In this sense, '*Who moved my nurse away?*' is a slightly different formulation of Celia Davies' 'polo mint' problem of nursing care in the UK in which nurses complain of being forced further and further away from direct patient care as they climb up the career ladder and enter management positions (Davies 1995). In the study setting, the 'gap in the middle' is created by the undervaluing of the 'care' aspects of nursing work by wider society that is reflected in the career choices of emerging generations of student nurses, few of whom are choosing to work by the 'bedside'. Consequently, the question asked by the speaker was a rhetorical means by which to illustrate the professional identity crisis created by nurses' moving away from their 'traditional domain' and the perceived threat to nurses' traditional role as providers of holistic care.

The problem of 'moving away from the bedside' was also attributed to BSc degree holders who aspire to further educational qualifications such as Masters Degrees, either as a means to secure better prospects for working abroad or to enter a career in nursing education. Here, a recurring theme was the concern that as educated nurses are not by the patient's bedside, neither patient care nor nursing practice is seen to benefit from the accumulation of academic knowledge or from the results of nursing research. As one speaker lamented, educated nurses are 'hidden away' in universities or within hospital administration and thus not visible to the public. Without putting the results of nursing research into practice, the possibility of evidence-based nursing practice in India therefore becomes more difficult:

Nursing research must be implemented. They should be clinically enacted and implemented, including by the person who has done the research. She must finish her thesis only when she has implemented her thesis.

The increasing trend for nurses to move from bedside care towards speciality fields was also linked to concerns among nursing leaders over the threat to occupational closure. The need to fill the 'gap' in the provision of general nursing functions poses the risk that other health professionals may be brought in by hospital administrations to take over some of this work. One example of this was found in a local hospice. The nursing superintendent described the difficulties in finding nurses to staff the hospice. Consequently, a number of caring functions of the patients had been delegated to ANMs and female community health assistants.

As Davies has argued, the appropriation of nursing tasks by those with little or no clinical training, presents the notion of nursing work as being largely 'unskilled' and has the added effect of further undermining the professional value given to care work (Davies 1995). By 'moving away' from the bedside, nurses as a collective group were seen as less able to protect their 'turf'. In the following extract, a speaker at the conference highlighted the dangers inherent to the professional project of nursing through losing its claim to professional status, i.e. being seen as an 'ayah', the collective term given to female cleaners in India:

You are nothing but a glorified ayah unless you say what is your domain! Dieticians have taken our work. Physiotherapists have taken our work! We are in a very precarious situation ... What is the use of having so many colleges giving a degree. What about practice?

For other nurses in the professional associations, engaging in many of the essential care activities required in bedside nursing was a waste of nursing 'skill'. This group promoted specialization as a form of professional prestige and highlighted the importance of developing advanced nursing knowledge and skills in speciality areas as a way to modernize nursing practice and meet the expectations of 21st century health care. Similarly, hospital nurses tended to favour both increased educational qualifications and specialization within nursing as a means to achieving greater professional status. As discussed in Chapter 4, the perceived lack of career opportunities in bedside nursing has resulted in the desire of nurses to specialize in areas perceived as 'in demand' particularly abroad. These include cardiology, renal nursing, psychiatric nursing, OT nursing, critical care and so on. Although this trend is particularly

notable in the narratives of recent nurse graduates who are keen to construct a nursing career in specialized nursing, older nurses interviewed also preferred to work in more ‘challenging’ areas than general bedside nursing. Nurses across age groups viewed a combination of educational qualifications and specialization as a means through which to forge a more meaningful nursing career and secure greater levels of job satisfaction. Many felt strongly that further educational qualifications were important to improve the image of nurses within and outside the hospital. As Saroj, a 33 year old nurse explained:

As people think that nursing is not an elevated profession, we would like for nurses to continue their education in the future. We want a lot of scope right? For PhD, for MPhils, for nursing nowadays we have got a lot of scope. So I would like all nurses to continue with their education in the future, not to just do a diploma in nursing. We also have a nice scope. We want further education.

In addition, increased skills and knowledge through further education (including ‘in-service’ training) was a means through which to demonstrate higher levels of expertise with doctors and being able to exert more autonomous decision-making power in relation to patient care.

The majority of hospital nurses therefore supported increased educational qualifications and clinical specialization towards building a ‘professional’ image of nursing in India. The tension observed in the narratives among the profession’s leaders that juxtaposed ‘holistic’ general nursing against fragmented, ‘specialized’ nursing was not seen to be as significant for nurses working in hospital practice. As highlighted in the previous chapter, emphasis upon ‘holistic’ care was evident in narratives of nurses working across clinical settings, including in specialized areas. Similarly, although some of the conference participants juxtaposed the image of Florence Nightingale against that of the ‘speciality nurse’ (for example, one speaker reminded the audience “*Florence Nightingale must be remembered in the clinical areas also*”!) this tension was not found to occur ‘in practice’. As seen earlier, nurses working across the sites often used vocational narratives to describe their work as nurses, including critical care nurses who told their own ‘Nightingale stories’ that recalled the image of the ‘lady with the lamp’. Therefore, while the narratives of nursing’s leaders presented a tension between modern and traditional visions of nursing, hospital nurses were found to reconcile both these visions in their descriptions of their daily lives as nurses and in their hopes for the future.

Another key site of tension in the narratives of older nurses was the perceived erosion of nursing values, particularly the notion of performing a dedicated ‘service’. There was a

palpable sense amongst the older generation of nurses that nursing values were being eroded through recent developments in nursing education. Younger recruits were perceived by older nurses as entering nursing predominantly for materialistic reasons and as nursing education was seen as predominantly a 'for profit' enterprise, the 'service' ethos of nursing was seen as fast disappearing. As Devi told me:

Nowadays these girls want only money. These people don't want to do the work. They want money only... In our time, we wanted to serve the people.

Whereas older nurses highlighted their training as being predominantly situated on the wards, 'modern' education was frequently criticised for being based on classroom learning, particularly for degree course students. Older nurses described their younger colleagues as being theory oriented and having limited clinical skills, thus leading to a 'theory-practice' gap. For example, Rose, a 45 year old nurse working in a central government hospital contrasted the practical experience of her generation with the theoretical experience of recent nursing recruits telling me:

In ours (training), we had practical exposure with the patients. In the present generation of colleges of nursing, there is no hospital set-up for them to learn. See, using dummies they do the demonstration. The dummy will not have the reflexes or give the opposite resistance when you are doing a procedure. When you are doing a procedure like putting tubes in the nose, there is resistance. So, they should learn on a live person. On a dummy, it will go inside easily. But with an unconscious patient?

'Rhetorics of nostalgia' were frequently employed by older nurses, particularly those in their 40s and 50s who described their training days as providing them with both the knowledge and discipline to practice nursing. Nursing education at that time was typically described as being very strict and somewhat militaristic in that a nurse's behaviour within and outside the hospital was highly controlled with strict observance of nursing 'rules'. Some nurses therefore contrasted their nursing training with that of the younger generation of nurses. As Vandana (58 years) explained:

We learned very good nursing. Nowadays, it is modern nursing. In our nursing time, it was very strict, no bindi (decorative mark on forehead). Before I went to nursing, I had a left side hair style. It was very strict, our tutor, told me not to have such a hairstyle. No Kajol (eyeliner), no bindi, because patients shouldn't comment on us. Because we have to serve them no? Daily our tutor was checking. No nail polish, no

*bindi, no kajol. Nowadays, with modern nursing, we are also telling that to our students. But nowadays, there are bindis, kajol and mehndi!*⁶⁸

Although the perceptions of inter-generational differences in nursing 'values' (such as demonstrating dedication and compassion and performing a 'service' to humanity) appeared to be a key feature of the rhetorics of nostalgia employed by older nurses, they also demonstrated a sense of protectiveness over nursing knowledge. Here, for many of the older generation of nurses, the threat posed by nursing education represented more than a loss of control over learning, but also undermined the essential values required to practice their profession. As will be seen by the following extract, for some nurses 'professionalization' was linked to the transformation of nursing from a 'calling' into a materially driven 'career'. The following extract is taken from a joint interview between Sophie (80 years) and her daughter Joy (47) where 'modern' nurses are depicted as being primarily motivated by material benefits.

Sophie: I feel that the nurses today, I feel so bad to say it, they are not as caring as we were. Let me put it that way!

Joy: It is a whole new generation. It is a whole new generation that also now, in your days, and probably when I also joined in, nursing was looked at more as a vocation, not as a profession. You went in because you didn't go in for the money or anything like that. You went in to do your job and your job satisfaction was not about the money. But these days it is professionalizing everywhere, they are trying to make it a degree course.

The narratives of some of the older nurses interviewed suggest that this generation is somewhat caught between acknowledging that nursing needed to modernize to find its place in a modern health system, and lamenting the 'old ways' that they felt were being eroded through 'modernization'.

Joy: I think things have advanced a lot. When mummy trained there was nothing available (technology). Now things have changed a lot...

SJ: And also in terms of the techniques in the profession, have they changed a lot do you think? And the kind of work that was expected of you?

Joy and Sophie: Oh yes!

Joy: I think for Mummy, it was mostly the actual care of the patients. Whereas for us, as we were training, we were expected to know a lot

⁶⁸ Mehndi is the application of henna as a temporary form of skin decoration and is typically applied on the palms and feet.

more about the illnesses. We were expected to know a lot more about the medical side of things- We were given a lot more responsibility when we were training.

Sophie: Now they go on computers!

Joy: Now yes, now of course, yes

Although Joy portrays some unease regarding the ‘professionalization’ of nursing, this is mainly related to a perceived threat to the traditional vocational values of nursing through their replacement with the notion of a ‘career’. As we have seen in earlier chapters (particularly chapters 3 and 4), although younger nurses were keen to construct a meaningful career in nursing, like other nurses across the data set, they also referred to the notion of performing a ‘service’ and consequently did not view the perception of nursing as a ‘career’ or ‘calling’ as incompatible.

Florence Nightingale as the unifying figure of Indian nursing

A particularly striking feature of the research data on professionalizing strategies was the importance bestowed upon Florence Nightingale as a ‘role model’ for Indian nurses. As discussed earlier, Florence Nightingale was frequently invoked by nursing leaders to instil a sense of fundamental nursing values in nursing students. In addition to the Florence Nightingale Awards that are held in different states and hospitals across the country, her image was displayed prominently at the conference as well as in the nursing colleges visited during the course of the research. Within the discourse of nursing leaders, Florence Nightingale was promoted as the ‘ideal nurse’ that all nurses should aspire to and whose life served as a point of reference in the development of nursing: “*patients should see that Florence Nightingale is standing in front of me*”, “*if you go back to the days of when nursing started and how Florence Nightingale started the profession until the 21st century, you will see so many changes*”, and “*we must maintain the vision of Florence Nightingale*” are examples of numerous references made to her in various speeches and comments at the public nursing events attended as part of this research.

Florence Nightingale never visited India. However, following her work during the Crimean war, she became concerned about the status of army hospitals in the country and also envisaged a role for Indian women in advocating for hygiene and sanitation particularly in the villages (Ramanna 2002). Given the sensitivity in India around the colonial period of Indian

history, I was initially perplexed by the adoption of a 'colonialist' figure as the collective symbol of Indian nursing and initially perceived her to be a somewhat 'archaic' symbol of Indian nursing's British past. I have now come to understand that the legacy of British nursing still exerts a strong influence upon nursing culture in India. As part of this legacy, Florence Nightingale serves to promote a common ideology among all nurses and as such, is used as an adaptable 'icon' by the profession. Given the increasing diversity and tensions among Indian nurses, Florence Nightingale functions as a robust unifying symbol that brings members of the profession towards a collective notion of 'ideal type' nursing values (e.g. dedication, compassion, service, duty) and particularly, promotes a central understanding of what it means to be 'a nurse'. Although reference to Florence Nightingale presents Indian nursing as a Western-style profession, it is possible that affinity to this global icon is perhaps a means to get away from local assumptions about nurses and, through emphasizing how all nurses must aspire to her standards regardless of religious and social background, functions as a social equalizer. By inculcating student nurses with a reverence towards Florence Nightingale's life and vision, the profession of nursing in India is able to exert some measure of control over the transmission of values seen as inherent to the profession. In this respect, Florence Nightingale provides a strong sense of a professional 'consciousness' for nurses in India and is used as a cultural anchor to bring the profession together.

Summary

Given the importance of knowledge to professional claims, professionalizing strategies advanced by nursing leaders emphasize nursing education as a fundamental mechanism to reposition nurses as holders of expert knowledge and skills and to resist the encroachment of competing professionals on nursing's jurisdictional turf. In addition to the importance of education to status claims, international nurse migration was also viewed as an important professionalization strategy for the nursing community in the study setting. While nurses were aware of, and acknowledged, the human resource constraints posed by shortages of skilled nurses, the opportunities brought through migration in terms of training and earning potential coupled with concerns over domestic nursing shortages, presented the profession with the possibility to negotiate greater social and financial rewards for its members in India.

Migration thus functioned as an important strategy towards achieving collective social mobility for Indian nurses.

Despite a collective desire to achieve greater social and professional legitimacy for Indian nurses, this study did not find a unified sense of professional identity among nurses in the study setting. Rather, in the construction of a collective professional identity, the profession is 'split' among those who advocate a return to 'old nursing' values and bedside nursing as a means towards reasserting nursing's position in the medical system, and those who promote a vision of 'new nursing' that emphasizes speciality nursing skills and increased educational qualifications. Hence, two potential visions of Indian nursing are presented as the 'way forward'. While this tension was largely resolved by nurses working in hospital practice who were more in favour of carving out a highly skilled role in an increasingly modernizing health system, there remains a strong sense through the data that nursing is not quite sure what it wants to 'be' in India.

The deep divisions among nurses as to the desired image and vision of nursing therefore point towards a 'fractured' notion of a collective professional identity for Indian nurses. Older nurses frequently referred to their concerns around the inter-generational loss of values in nursing and lamented the change in the 'character' of nursing from a 'service' driven 'calling' to a 'materially' driven 'career', at the same time welcoming some aspects of modernity in nursing practice. Furthermore, government and private nurses were presented in the narratives as decidedly different professional entities, where the distancing of private nurses from their government counterparts presented the image of a divided profession in which 'loyalties' appeared to run along institutional lines. Despite being a strong rallying symbol for nurses, emphasis on the vision of Florence Nightingale by nursing leaders to encourage internal cohesion appeared to function as a way to 'paper over the cracks' in understandings of a collective identity of nurses. While Florence Nightingale certainly provided a strong shared sense of a professional consciousness in nursing, the internal divisions found to characterize the profession's understanding of itself were seen to promote a sense of 'anxiety' as to the direction of nursing in India and, moreover, a contested professional status.

Chapter 7

Discussion

This study is one of the few detailed examinations of the nursing profession in a non-Western context. It has investigated various features of nursing culture in a modern, urban Indian setting and the factors underpinning notions of professional identity among Indian nurses. The study involved an in-depth investigation of decisions to join nursing, the types of career opportunities envisaged by nurses, accounts of nursing practice in hospital settings and the professionalizing strategies debated by the profession's leaders to achieve greater social and professional legitimacy for nurses as an occupational group. Although the study has been restricted to the city of Bangalore, the city serves as a major migratory destination for job seekers from all over India and as such was an opportune environment in which to investigate the social and professional backgrounds of nurses, many of whom come from surrounding Indian states.

The main conclusions of this study are firstly, that a confluence of local and global perspectives characterizes the professional project of nursing in contemporary India in which nurses are seeking to carve a new identity both within the Indian medical system and in wider Indian society. Secondly, while nurses are connected by shared concerns around a stigmatized social identity and a desire for collective social mobility, tensions within the profession were found to contribute to a 'fractured professional identity'. This was marked by inter-generational differences, divisive accounts of nursing in public and private institutional settings and competing visions of the future of Indian nursing. Furthermore, the interview narratives point towards an increasingly diversifying profession many of whose members are keen to pursue global careers, work in specialized clinical settings and pursue further education, and whose sense of professional identity is strongly influenced by these career choices. At the same time, nurses are brought together at a discursive level through the example of Florence Nightingale as the embodiment of essential values in nursing and whose legacy exerts considerable influence over nursing culture in India.

India is a pluralistic and complex society with multiple and intersecting social divisions related to language, religion, gender, caste and class. Therefore, as Gupta (1992) rightly points out, it may be 'tempting' to construct 'Indian theories' of social phenomenon and not examine the relevance of broader theory to Indian society. Many of the findings of

this empirical study of nurses in India resonate with literature on the professions as well as studies of nursing in other contexts. At the same time, this study is one of the few that examines the relationship between professional identity and the wider social system in India. In the following chapter, we shall discuss points of convergence with other studies, as well as areas where the findings of this study provide a new dimension to knowledge of the sociology of the professions.

Nursing, professionalization and collective social mobility

Nursing in its modern form can be understood as a relatively new profession in India in that its growth occurred during the colonial expansion of medical services and education in the second half of the 19th century. The emergence of Western style nursing in India mapped onto historical social divisions in which nursing became associated with the traditional caste based division of labour and with low status work. In the Indian caste hierarchy, notions of 'purity' and 'pollution' within the body are not easily demonstrated through physical characteristics, but rather, come to be signified through rituals and social practices that separate higher and lower castes in the public arena (Gupta 1992). As we have seen, due to its association with menial work, nursing has traditionally been viewed as a 'polluting' occupation that presented a threat to the social identity of those from the upper castes and thus was not an acceptable choice of employment for women from high caste families. Despite being rooted in Hindu philosophy, the stigma attached to 'polluting' work has spread beyond the boundaries of Hinduism into wider Indian society and as such, has taken on a wider normative power. Consequently, nurses from both Christian and Hindu backgrounds complained about the negative associations attached to nursing work and were eager that the profession strategize to cast off a stigmatized social identity. The desire of many young nurses to leave 'bedside' care for a specialized career may therefore reflect a desire to move up the pollution-purity hierarchy by shedding 'polluting' activities connected with the daily care of patients and taking on tasks associated with the high status profession of medicine.

Although the image of nurses in the public consciousness has begun to change largely due to the perception of nursing as an economically profitable and geographically mobile enterprise, the preoccupation of the profession's members with the effects of historical prejudices on the social identity of nurses have fundamentally affected the profession's image of itself. The renegotiation of a stigmatized identity is therefore at the heart of

professionalizing strategies being adopted by nursing's leaders, career strategies envisaged by nurse graduates, as well as in the moral accounts presented by hospital nurses in their depictions of nursing practice.

The findings of this study therefore support the notion that professional projects are characterized by a desire for collective social mobility (Larson 1977; Macdonald 1995). For Indian nurses, strategies underpinning collective social mobility include pushing for increased social and economic rewards to ensure higher professional standing and a higher social status for members of the profession. A movement through 'economic space' is accompanied by a corresponding movement through 'social space' thus leading to a change in 'social environment' (Mach et al. 1978). For the nursing profession, greater occupational prestige through shedding undesirable work becomes a means through which to acquire greater *social* prestige and is thus a key part of achieving a 'status renewal' in social identity.

In urban contexts in India, the forces of globalization are much more evident than in rural areas of the country, so that in cities such as Bangalore increased secularization and economic prosperity has led to a growing middle class and a gradual erosion of traditional caste divisions.⁶⁹ Globalization offers individuals with the potential to carve new social spaces particularly through the introduction of skill-based meritocratic hierarchies in which knowledge and competency are given precedence over traditional social hierarchies (D'Mello and Sahay 2007). For nurses in Bangalore, globalization has introduced the potential for status renewal. In this urban setting, nurses are able to actively engage with the possibilities brought by globalization, particularly through the construction of new 'hi-tech' corporate hospitals catering to the upper and middle class as well as foreign 'medical tourists' to India, many of which have ties to hospitals and medical institutions in Western countries. Such international networks thus foster another important feature of globalization i.e. the possibility for 'mobility' and the prospects of a global nursing career.

Nursing is a striking example of a globally mobile occupation. For women in particular, international migration offers economic and social benefits as well as an escape from traditional assumptions and obligations that are an important part of the social fabric of India. As Percot found in her study of the migration of female nurses from Kerala to the Gulf, nurses contrasted their experience of increased personal autonomy and the independence of

⁶⁹ I am not implying that social inequalities do not exist in urban contexts such as Mumbai and Bangalore. Rather, Indian cities are characterized by greater fluidity in caste relations in which caste status is increasingly considered less important as a social maker than income and 'class' status that greatly influence an individual's access to further education and employment (Beteille 1992).

nuclear family life in the Gulf with extended familial and community expectations 'at home' in Kerala (Percot 2005). In this study of nurses in Bangalore, both female and male nurses overwhelmingly acknowledged that the poor image of nurses in the public mind was gradually being replaced by the perception of nurses as educated, international 'globe trotters' and frequently referred to the surge in demand for female nurses as marriage partners as 'proof' of this transformation. These findings therefore support Percot's view that nurse migration is an important life strategy for young female nurses. In addition, this thesis argues that migration also serves as an important strategy towards achieving collective social mobility for the profession.

As discussed in Chapter 3, the prospects of economic rewards through nursing are not only a consequence of globalization. Nursing has long offered women the possibility of earning an independent income where, for the older generation of nurses in particular, becoming a nurse was one of the few employment opportunities available. For many nurses without the support of husbands and families, nursing provided a measure of financial independence, while for others, entry into the profession enabled women to contribute to family earnings. As Sheba George argues with respect to Kerala, increasing employment opportunities in India and abroad through entry into nursing helped transform Keralite women from 'burdens' to 'economic assets' and consequently, many families began to push female members into the profession (George 2005). Through my research, I have found that the viability of nursing as a form of employment for women has contributed to the creation of extended 'nurse families' in which nursing resembles an inherited female trade. Consequently, this study is the first to note the development and function of 'nurse families' in India as a consequence of nursing's history as a gendered occupation.

Emerging opportunities for nurses through higher education and employment mobility has attracted a number of new recruits into the profession, particularly those from other religious and caste backgrounds, and the increased entry of young men. While nursing remains a predominantly female profession in India, the perceived employment opportunities for male nurses has resulted in an increased demand for a nursing qualification among young men. Almost half of the student body of one of the nursing colleges visited was composed of male nursing students. Some commentators view these changes as 'mixed blessings' for the profession, particularly as the demand for a nursing qualification is driving up the costs of education. For example, while Somjee welcomes the changes in nursing over the past twenty years, she laments that the increasing presence of 'newcomers' from higher castes and socio-

economic backgrounds may be pushing out lower castes that need access to the employment prospects through nursing more than the former for increased economic and social stability (Somjee 1991).

As found in this study, nursing education presents an affordable option for lower middle class families with the potential for high economic returns particularly through international employment. The costs of nursing education are prohibitive for those from low income families, and thus nurses coming from poor backgrounds were frequently the recipients of reserved government seats in educational institutions for whom fees are waived. Recent media reports indicate that nursing fees are becoming significantly higher in Karnataka alongside a reduction in education loans for nursing students from Indian banks (*The Hindu*, February 27th 2010). Although these have been reportedly brought to the attention of the Indian Nursing Council and State Councils, it is likely that a combination of these factors may offset the 'opportunity cost' associated with nursing (i.e. that the costs of nursing training can be quickly paid off through the relative ease of finding employment) and in doing so, affect the participation of those from lower middle class families who form the main recruitment pool for the profession. It therefore remains to be seen whether the factors that designated nursing as an accessible job 'with prospects' for previous generations of nurses will continue to be viewed as such by future generations of young women and men.

Constructing careers in nursing

There is a large body of literature on 'careers' within the social sciences. A notable portion of this literature falls within psychology and particularly examines careers as life development processes or 'phases' where stages of an individual's life affect and refine his or her life choices. These phases include age-related achievements, transitions and critical incidents that occur over the course of a life time (Marshall 1989). Psychological literature on careers also includes vocational guidance in which distinctive traits of individuals are identified with the aim of providing guidance as to suitable career paths and for managers, identifying ways of maximizing the efficiency of employees within organizations (Betz et al. 1989; Brown et al. 2004). Careers have also been examined within sociological and anthropological literature where careers are related to social roles, class mobility and to 'status passages' (Arthur et al. 1989).

'Career theory', the corpus of theories devoted to understanding and analysing careers has been criticized for being modelled on the experiences, aspirations and psychology of men working within bureaucratic organizations (Marshall 1989; Gallos 1989). Women's careers typically involve a combination of employment, marriage and motherhood, where the central theme is the individual's life rather than a series of sequential occupational stages (Marshall 1989). For example, Marshall and Gallos's chapters in Arthur and colleagues' (1989) comprehensive volume on career theory challenge the notion of careers as being linear trajectories through hierarchical organizations and seek to locate careers within the broader context of women's life development.

The findings of this study therefore support theories around the development of careers from a feminist perspective that argue that women's careers are constructed in relation to key life events and not detached from those events. Adopting this perspective has been particularly helpful towards understanding the work histories of the nurses in this study, most of whom used the term 'career' to describe retrospective or prospective work decisions and located these decisions around key life events such as marriage and child bearing. For example, for many nurses in the study, the desire to migrate abroad was strongest *before* marriage. For female nurses particularly from Kerala, migration before marriage offered the possibility of earning an income to contribute to the costs of marriage and towards payment of 'dowry'. For other nurses, migration after marriage was considered problematic if they did not have their husband's support and especially, if they had young children.

While many of the interviews with female nurses indicated the centrality of life events such as marriage and children to key career decisions in nursing, the interviews with male nurses did not indicate any such planned career breaks. The relatively continuous career paths of male nurses appears to be a reflection of societal gender norms in which female nurses assume their responsibilities as wives and mothers, and consequently plan their careers around these expectations. At the same time, the narratives of female nurses recounting their working lives illustrate how nursing acts as a life-long source of employment. These accounts demonstrate the relative flexibility of a career in nursing that makes it possible to 'take a break' and return at a later point in time. For instance, nurses frequently mentioned temporarily suspending their careers to get married and look after children and then re-enter nursing later. Nursing is thus portrayed as an important resource that can be 'called upon' at various stages in life.

Although careers are commonly seen as referring to ‘upwards’ mobility, climbing ‘the career ladder’ is only one type of career progression (Arthur et al. 1989). As demonstrated by the interview data, careers do not necessarily involve upwards linear mobility, but are frequently characterized by non hierarchical ‘horizontal’ work transitions. This was a feature of the careers of both male and female nurses whose working lives consisted of moves between both vertical and horizontal work roles, such as from one speciality to another, one institutional setting to another, as well as moving up the chain of nursing management. Careers also tended to be located in one type of institutional setting (i.e. public or private) where nurses frequently depicted these settings as different and often opposing cultures of care. Nurses interviewed in the private sector had considerably more varied work histories than nurses in the public sector and had worked for periods of time in nursing homes, mission hospitals and other private facilities, whereas many of the government nurses interviewed had worked in only one or two government hospitals following initial registration.

Understanding the ways in which careers are constituted in the study setting is important towards a more critical examination of the concept of ‘career’ and its cultural determinants. A feature of career theory is its focus on individual decision-making or ‘agency’ (Chen 2006). As Marshall argues, the notion of individual ‘agential’ decision-making is also a characteristic of male centric career models in which values such as ‘independence’, ‘self assertion’ and control of the environment are promoted (Marshall 1989). Women’s careers on the other hand, are predominantly characterized as ‘dependent’ and influenced by networks of social relationships (Marshall 1989). As discussed earlier in this thesis, in my examination of nurses’ narratives around their careers, I have investigated the extent to which nurses’ accounts demonstrated an individualistic and ‘agential’ approach to a nursing career or whether careers were part of a ‘collective project’ where nurses predominantly situated their employment choices within those of their family and community networks.

This study found that career decisions undertaken by nurses were part of a communal decision-making process involving the consultation and support of family and peer networks. Female nurses typically required the support and approval of husbands and extended family members, particularly ‘in-laws’ for key decisions around work. For example, some nurses reported being pressured to discontinue working while their children were young and encountered resistance from in-laws upon their decision to continue nursing after marriage or after the birth of their children. Here, spousal support was frequently necessary to override

this resistance and to re-enter nursing practice. For nurses considering overseas employment, the support of parents (in the case of unmarried nurses), husbands and families was also particularly important.

This communal framing of decision-making was not just a feature of women's career decisions, but those of all nurses. As highlighted in this thesis, Indian society is characterized by the importance of collective identity over individual identity. Decisions are frequently communal and hierarchical where elders in the family and community often exercise greater decision making power over younger members. Consequently, career theories emphasizing individual 'agency' that have been developed predominantly in Western bureaucracies require some rethinking in non-Western contexts where decision-making processes are typically influenced through wider networks. As found in this study and in George's account of Keralite nurses living in the United States (see George 2005), Indian nurses are able to learn about job opportunities, visa processes and living arrangements via community networks that also provide social support. Networks served as critical social and professional resources for male and female nurses and were important in the design of a nursing career. Networks utilized by nurses in the study setting include 'nurse families' as well as both 'social' (kin, community and nurse 'batch-mates') and 'professional' networks (doctors, nurses and other work colleagues) and had multiple functions. These functions include support and advice, acting as 'news wire' through which information on vacancies and, for those nurses headed overseas, helping them 'settle'. Overseas networks were particularly important to nurses from Kerala, many of whom were keen to join friends and family members already working abroad.

Migration: 'push' and 'pull' in context

Theories around migration have typically followed the 'push-pull' paradigm where people move from one place (sending culture) to another (receiving culture) for better social and economic opportunities, but also for political and religious reasons (Harzig 2001). 'Push factors' include a broad range of environmental, institutional and individual level factors that motivate health workers to migrate overseas. These include low salaries, poor working conditions, burn-out and a perceived lack of career opportunities as well as macro socio-economic issues such as war, civil unrest and poor economic performance (Dovlo 2005; USAID 2003; McCourt and Awases 2007). 'Pull factors' are those which often mirror those

that ‘push’ migrants to leave their home country and include prospects of better standards of living, pay and career incentives. This approach however has been criticised for promoting a linear view of migration, where people are seen to move in one direction i.e. from the sending to receiving community (Harzig 2001). As Harzig argues, a linear view of migratory pathways is also based on gender stereotypes:

Central to this perception was the male pioneer, daring to venture into the unknown, scouting out the terrain, setting up structures for the woman to follow. (Harzig 2001:16)

Within the ‘push’ and ‘pull’ paradigm, Europe and North America are seen as the main desirable international destinations for migrant workers leaving their countries of origin.

Studies of health workers, and particularly those of nurses, demonstrate that rather than being unilateral and/or permanent, migratory pathways are complex and sometimes include multiple destinations within countries as well as geographic regions. They can also frequently result in the migrant returning home to his or her country and place of origin. Studies of nurse migration for example, have frequently shown that nurses may migrate numerous times for various reasons (Buchan et al. 2005; Larsen et al. 2005; Alonso-Garbayo and Maben 2009). There have consequently been some conceptual shifts in academic discourses around patterns of migration away from a focus on a unilateral model. For example, terms such as the ‘global carousel’ of health workers to capture patterns of migration are more frequently used (JLI 2004; USAID 2003; Kingma 2006). However, gaps remain in knowledge around the dimensions of international migration, including how long health workers stay in each place, or why they return home. Also, as Buchan and Dovlo argue, not much is known about the profile, motivations and plans of health professionals, including nurses, who have made an international move (Buchan and Dovlo 2004).

This study therefore contributes to available knowledge of nurse migrants from India. Unlike other studies that have examined migration as the main career decision undertaken by nurses, this research locates migration within the broader framework of career decisions that were typically considered by nurses in the study setting. In this respect, the study demonstrates that the decision to migrate is one of other key career choices for nurses in Bangalore, that also include decision-making around the choice of clinical speciality, institutional setting and the possibility of undertaking further educational qualifications in nursing. Furthermore, most studies of migrant nurses from India focus on the migratory plans and experiences of nurses from Kerala. While this is understandable given that there is a very

high level of migration from Kerala to the Gulf, Europe and North America compared with other Indian states, the focus on nurses from Kerala has meant that much less is known about other groups of Indian nurses as well as the ways in which nurses from Kerala represent a distinct migratory community.

This study found notable differences in the profiles of prospective migrant nurses across the data set. For example, nurses interviewed in the private hospitals were on the whole younger and more geographically mobile, often expressing an interest in overseas employment. The desire to migrate was less evident among government sectors nurses, the majority of whom were from Karnataka. As we saw in Chapter 4, working in the government sector is associated with life stability and thus may explain why nurses on permanent government posts did not appear to view migration as a key career strategy.⁷⁰ As few studies to date have compared the migratory pathways of nurses working in public and private contexts, this finding therefore presents an additional structural dimension to consider in investigating factors underlying international nurse migration. Unlike some studies that report that nurses working in the public sector tend to experience greater dissatisfaction with pay, workload and resources than private sectors nurses (see Pillay 2009) this study found that government nurses were typically more satisfied with pay, benefits and educational opportunities than nurses working in the private sector. However, government sector nurses who did express an interest in overseas employment cited similar reasons to private sector nurses, particularly the ability to 'earn more and learn more'. This suggests that the possibility of increased professional status and economic rewards through employment is a powerful motivating factor for many nurses, regardless of institutional setting.

Interview data revealed that that nurses who articulated an interest in overseas migration were typically younger (in their 20s), work in private hospitals, are unmarried and came from Kerala.⁷¹ Out of sixteen Keralite nurses interviewed, five had already migrated

⁷⁰ The government nurses interviewed were on permanent government posts and were not 'contract' nurses that are hired by the government to boost nursing coverage in government hospitals. These nurses do not obtain the same benefits as those holding fixed posts, namely pension and education. Consequently, this category of government nurses may be more mobile than those holding fixed post positions. Similar findings have been reported by Thomas (2006).

⁷¹ This finding corresponds with surveys on migration from Kerala, where migrants were found to be aged between 15 and 34 years at the time of migration (Zachariah et al 1999). Zachariah and colleagues' examination of a large scale household survey in Kerala conducted in 1998 found that the average age of an emigrant was 27 years the age of a return migrant was 34 years. The authors also found that the average Kerala migrant returns home after a seven year stay abroad, where this was similar for both male and female migrants (Zachariah et al 1999).

overseas and six expressed the intention to migrate (n=11).⁷² Unlike communities from Karnataka, Keralites have strong overseas networks where nurses from Kerala began migrating to countries such as the United States from the 1960s and to the Gulf in the 1980s, many of whom accompanied their husbands who were employed in the Gulf following the 1970s oil boom. Migration from Kerala particularly to the Gulf countries⁷³ exerts an extremely important influence on the state's economy through the sending of remittances that have been estimated to constitute as much as seven times what the state receives from the Government of India as budget support and almost twice the state's annual budget (Zachariah and Rajan 2004).⁷⁴ Of the five Keralite nurses who had no plans to go abroad, three felt that this had only been possible before their marriage and were now reluctant to leave their children. A further two Keralite nurses had been interested in migrating, but their husbands did not agree.

In their interviews, nurses from Karnataka typically expressed less interest in migrating abroad than their Keralite sisters and preferred to stay in India. Nineteen out of thirty-four nurses from Karnataka stated that they did not plan to leave India and were not interested in working overseas. An additional nurse (59 years) explained that she had previously been interested in migrating abroad but did not pursue these plans due to family reasons. She now felt that it was 'too late' in her career as she was close to retirement. Other nurses from Karnataka cited family reasons for their desire to stay in Bangalore, particularly the reluctance to leave their parents and children behind and wanting to stay in India.

As Bangalore is a large, cosmopolitan city, working in Bangalore may be viewed by some nurses as equivalent to moving abroad. For example, a few nurses from rural areas in Karnataka explained that migrating to Bangalore was itself considered an important transition and that their families would not be supportive of their desire to leave India. In addition, as many 'localite' nurses from Karnataka have settled in Bangalore and have families, friends and a strong social network in the city and surrounding areas, they do not have the same overseas networks as Keralite nurses and thus may feel less comfortable in making such a radical move to unfamiliar cultural contexts. Nurses from Kerala have already migrated to Karnataka, where they are essentially 'outsiders' and do not share the same language or

⁷² It is important to note that the interview narratives expressed an *intention* to migrate and may not necessarily result in actual migration.

⁷³ This has been estimated at about 90% of total out-migration from Kerala (Zachariah and Rajan 2004).

⁷⁴ As found by Zachariah and Rajan who analyzed data on overseas remittances between 1999 to 2004, households in Kerala received remittances in the form of cash, commodities and funds for investing in property, cars, scooters, small businesses as well as meeting dowry expenses (Zachariah and Rajan 2004).

customs as native Kannadigas. As Binod Khadria argues in his study on the migration of IT workers, Bangalore functions as an important corridor for migration to and from India (Khadria 2004). Consequently, migration to Bangalore is one step along the migratory pathway for many nurses from Kerala who are able to gain work experience in the city's various private hospitals before applying for positions abroad. Overseas migration therefore represents another step in this chain.

The examination of the cultural specificity of migrant communities, such as those from Kerala, is important to the study of migration as the prevalence of overseas employment within some communities may render migration as something of a 'rite of passage' for the community's members. Nurses from Kerala interviewed in this study frequently mentioned family members, relatives and friends who had already travelled abroad thus creating some cultural pressure to follow suit.⁷⁵ References to such overseas networks emerged less frequently in the narratives of nurses from Karnataka. Consequently, in addition to 'push' and 'pull' factors related to social and economic rewards, theories related to migration need to take into consideration the cultural acceptance of overseas employment and migratory trends of some communities over others.

Some nurses from Karnataka (n=8/34) did highlight an interest in seeking overseas employment and mentioned similar reasons to nurses from Kerala, particularly the desire to gain increased knowledge, skills and expertise through working in foreign hospitals and earning a higher salary than in India. Four nurses from Karnataka had already migrated abroad, of which three were return migrants and one currently resides in the UK. In addition, three additional nurses (one from Karnataka and two from Kerala) stated that they had previously considered seeking employment overseas but as their husbands did not support this idea, they dropped these plans.⁷⁶ As stated earlier, the support of husbands for female nurses planning to migrate abroad appears to be fundamental for the decision to migrate for nurses regardless of 'home state'.

This study also found that the majority of potential migrant nurses were keen to return to India and thus not permanently settle abroad. Almost all nurses interviewed, including nurses from Kerala, who were keen on seeking overseas employment did not envisage this to be a permanent move and planned to return either to Bangalore or to Kerala. The desire to

⁷⁵ Overseas migration is also common among all religious groups in Kerala (Hindu, Muslim and Christian), however is relatively less prevalent among Hindus from Scheduled Caste and Scheduled Tribe backgrounds (Zachariah et al 1999).

⁷⁶ One male nurse from Karnataka did not provide any information as to whether he would be interested in seeking overseas employment.

return to India has been reported in other studies of migrant workers, including doctors, nurses and IT workers (Zachariah et al. 1999; Khadria 2004). For example, Zachariah and colleagues also found that the average Keralite migrant returns home after a seven year stay abroad, where this was similar for both male and female migrants (Zachariah et al. 1999). Similarly, in his study on the migration of Bangalore based IT workers overseas, Khadria found that none of the forty-five professionals interviewed as part of the Bangalore case study expressed definite interest in permanent overseas migration. The IT professionals interviewed in Khadria's study cited the growing employment and career opportunities in Bangalore as the country's 'Silicon Valley', as well as its modern and cosmopolitan character and pleasant climate as major reasons why they planned to return after some years abroad (Khadria 2004).

For many nurses, therefore, migration was envisaged predominantly to satisfy their career objectives of achieving increased knowledge, skills and economic rewards in a relatively short period of time that could result in long-term professional and social status gains 'back home' in India. In addition to the pull of Bangalore as a 'desirable place to live', return migration to the city may also be explained by the tendency of nurses to migrate initially to the Gulf States where it is considerably more difficult to obtain visas for spouses or children as well as to assimilate with the local population (Nair and Percot 2007). Consequently, nurses migrating to the Gulf may be more likely to return to India than those with the possibility of relocating with their families to countries such as the United Kingdom and the United States.

In global discourses around international public health, physicians and nurses are seen as essential human resources for health and their potential migration represents an important threat to governments in managing the provision of health care. In addition, the costs of training skilled health workers and the subsequent loss of this investment through emigration are also being measured in both financial and social terms (Muula et al. 2003). Consequently, there has been increasing emphasis on 'managed migration' policy responses at the international level that include bilateral agreements between source and destination countries and ethical recruitment codes.⁷⁷ Although health worker migration is undoubtedly a concern for some countries facing a severe depletion of their reserves of trained health staff, in others, it has also been suggested that the focus on health worker shortages is something of a 'red herring' (Kingma 2006). Kingma argues that many trained nurses choose not to work under

⁷⁷ See the *Commonwealth Code of Practice for the International Recruitment of Health Workers* (2003) London: Commonwealth Secretariat and the *Code of Practice for the international recruitment of healthcare professionals* (2004) London: Department of Health.

conditions of low pay, high workloads and other factors where discontent with working conditions has led to attrition of the nursing workforce. Kingma writes:

there are approximately half a million nurses in the United States- 20 percent of all registered nurses- who renew their licenses to remain on the register but choose not to work in nursing under current conditions. There are many examples to indicate that nurses love their profession but hate their job. (Kingma 2006: 40)

Kingma also expands the concept of 'migration' to include the pathways of nurses who migrate within national borders but away from health care to health industry (e.g. from hospitals to pharmaceutical firms), as well as outside the health system entirely. Consequently, these nurses are still living and registered in their home countries but are not currently working.

In her study of prospective nurse migration from Delhi, Philomena Thomas found that dissatisfaction with working conditions, pessimism regarding fulfilling the ideals of nursing, and unhappiness with social attitudes towards nurses were important factors underlying nurses' decisions to migrate (Thomas 2006). Similarly, Khadria's study of Delhi based nurses planning to move overseas highlighted stagnant career opportunities, and a lack of education and training facilities in India as motivating factors frequently cited by nurses. Kingma's important point that many nurses "*love their profession but hate their job*" touches upon a theme that emerged strongly in this study, namely that in addition to the prospect of individual and social rewards through individual migration, migration was perceived as a mechanism through which nurses could achieve collective social and economic rewards for the profession as a whole, particularly higher salaries, increased professional autonomy and higher social value. Reports of the 'scarcity' of nurses in the Indian media that frequently blame migration for nursing shortages in the country therefore act as an important bargaining tool for the profession's leaders to negotiate improved remuneration and employment conditions for nurses, particularly for those working in hospital settings.

Rather than being a 'hidden' process, this study found that migration was discussed openly by members of the nursing profession and where a recruitment agency was invited to attend the state level nursing conference. In addition, as Khadria notes, despite high turnover rates among hospital nurses particularly in the private sector, many of the country's well known private hospitals are taking advantage of this phenomenon by recruiting nurses and preparing them to take foreign nursing exams, many of whom have 'tie ups' with hospitals based in the United States (Khadria 2007).

It is not that migration does not provide a dilemma for nurses in India, many of whom are well aware of nursing shortages in the country. Rather, as Thomas suggests, it is perhaps time for a discussion of the 'pros and cons' of international migration of Indian nurses that takes into consideration the working conditions and professional expectations of members of the profession (Thomas 2006). Whereas policy level discourses around migration have focused on individual 'push' and 'pull' factors that encourage international nurse migration, these discourses could be expanded to include concerns around professional autonomy, career incentives and professional status that act as collective factors underpinning the migration of nurses as an occupational group. As will be discussed in the section below, Indian nurses share many of the same professional concerns as nurses working in other countries, particularly concerns around the feasibility of the current nursing mandate in the context of current health care delivery systems.

Professional identity and the nursing mandate

As has been found in other settings, the nurses interviewed in this study viewed the provision of holistic care through attention to the physical and psychological needs of patients as an essential part of the nursing mandate (Bolton 2000; Henderson 2001; Gray and Smith 2009). The fostering of therapeutic relationships with patients through emotional labour was depicted by nurses across the study sites as a key aspect of providing care and central to the professional identity of nurses. Nurses frequently portrayed nursing as a caring and dedicated profession in which its members went beyond the medical treatment provided by doctors. Such moral accounts of nursing emerged strongly in the narratives of critical care nurses who told extended nurse-patient accounts ('Nightingale stories') to demonstrate the therapeutic value of nurse-patient relationships and their role as patient advocates. As May and Flemming have argued in their discussion of the 'professional imagination' in nursing, nurses in this study used the 'caring' mandate of nursing to construct its difference from medicine and achieve occupational closure (May and Flemming 1997). Narratives such as 'Nightingale stories' that place holistic care at their centre, therefore support May and Flemming's assertion that such accounts function as professional discourses in which nurses project a strong sense of self identity through 'every day' descriptions of nursing practice (May and Flemming 1997).

The feasibility of 'holistic care' in contemporary nursing practice, however, is increasingly under review (Davies 1995; Dingwall and Allen 2001; Allen 2004; Maben et al. 2007). In the United Kingdom, for example, the introduction of 'managed care' through the National Health Service (NHS) has resulted in the employment of different categories of health workers, including Health Care Assistants (HCAs) who have taken on a large portion of the traditional bedside care activities of nurses. In this environment, 'care work' is broken down into a series of 'tasks' that are typically carried out by different people, under the overall supervision of nurses who in turn, find themselves in co-ordinating, liaison and management roles (Maben et al. 2007). Similarly, Davina Allen's review of nursing studies demonstrates that nurses are engaged in activities that designate their role as that of an 'health mediator' where nurses, inter alia, manage the work of others, record, assess and communicate information to patients and doctors, as well as prioritize care provision and ration resources (Allen 2004). Managerialism is thus at odds with the 'primary nursing' system of care where 24 hour responsibility for individual patients is allocated to individual nurses. Nursing careers also typically take nurses up the management chain, as well as into research, education and advanced nursing practice so that holistic care by the 'bedside' is typically provided by newly qualified nurses, students and other auxiliary categories of health workers (Davies 1995).

Another challenge to the profession's claim towards 'holistic care' is the adoption of a caring mandate by medicine through general practice. As Rosemary Pringle argues, the male professional project of medicine is gradually shifting from viewing female doctors as being outside of mainstream medical practice towards a more 'human face' of medical care, based on a more female driven approach (Pringle 1998). The 'patient sensitive' practice style attributed to women doctors is characterized by a better 'bedside manner', empathy and communication with patients, skills that are increasingly valued by the medical profession and by the public as a key attributes of a competent physician (Martin et al. 1993). In addition to transforming the social and professional dynamics of medicine, the fostering of therapeutic relationships with patients by general practitioners may have important implications for the traditional boundaries between medicine and nursing, particularly the distinction that is often made between medical 'treatment' and nursing 'care'. For example, in her chapter on doctor-nurse relations, Pringle notes that a transformation of medical practice from a focus on the provision of treatment to a more holistic approach adopted by women doctors is "*fast taking from nurses their monopoly of 'caring' functions*" (Pringle 1998: 194).

Consequently, the emphasis on holistic care within nursing is increasingly being debated by nurse academics, some of whom have begun calling for a revision of the nursing mandate to reflect what nurses 'actually do' in practice (Allen 2004; Dingwall and Allen 2001; Maben et al. 2006). In their longitudinal study of newly qualified nurses in the NHS, Maben and colleagues report that the majority of newly qualified nurses became disillusioned with the realities of nursing practice compared to the values and ideals emphasized in the nursing educational curriculum (Maben et al. 2006). Rather than being able to carry out sustained and holistic patient care, nurses interviewed eleven to fifteen months following qualification were involved in general administration, drug administration and in liaison and communication roles (Maben et al. 2006). Such discrepancies between the nursing mandate reflected in nursing education and nursing practice are therefore at the crux of the frequently mentioned 'theory-practice gap' in nursing (Allen 2004; Maben et al. 2006; Price 2008). Dingwall and Allen argue that holistic care based upon emotional intimacy with patients is increasingly unrealistic and overambitious in the context of hospital based health care (Dingwall and Allen 2001). Concern around the dwindling practice of 'bedside nursing' is also reflected in a 2002 editorial in *Nursing Inquiry* where Nelson and colleagues examine the question as to how bedside nursing can be "*saved from extinction*" in the twenty-first century (Nelson et al. 2002). In a series of questions put to readers, Nelson and colleagues ask how bedside nursing can be promoted as an attractive long-term career and not just an intermediate step to careers in advanced practice, academia or outside the field altogether (Nelson et al. 2002).

Similar debates, particularly those regarding a re-emphasis on bedside nursing, were also found to characterize discussions on contemporary nursing practice in India. As has been reported elsewhere, career structures that take nurses into management and a preference for advanced nursing practice were factors attributed to the difficulty in retaining nurses in bedside care. In addition, as discussed in the previous chapter, a number of nurses active in the nursing associations and in academia highlighted their concern that nursing was increasingly 'moving away' from the bedside and thus away from nursing's 'heritage'. For others in the profession however, moving on from a focus on general nursing skills towards advanced practice was viewed as a somewhat inevitable consequence of the professionalization of nurses. For the professions in particular, possession of esoteric knowledge is the basis upon which claims to professional status are made (Jackson 1970; Hughes in Coser 1994). Consequently, the desire of many nurses to acquire additional skills

and knowledge in speciality areas reflected the concern that general nursing knowledge was not sufficiently esoteric to acquire professional authority and status. For this group, advanced nursing skills were promoted as a means through which to secure the profession's future in 21st century health care provision in India.

Further tensions were observed between the narratives of hospital nurses and the public discourse of nurse leaders at the nursing conference who were concerned about the waning influence of holistic care in hospital nursing. As demonstrated by the narratives of nurses across the sites, and particularly by 'Nightingale stories', hospital nurses valued their relationships with patients as a integral part of nursing and saw no contradiction in entering advanced clinical practice and maintaining therapeutic, 'holistic' patient-nurse relationships. In addition, in the hospitals visited as part of this research, the majority of bedside nursing duties were carried out by staff nurses and nursing students under the supervisor of ward sisters rather than by auxiliary categories of health workers.⁷⁸ This suggests that the use of auxiliary care staff in hospitals is not yet as routinely implemented in Bangalore's hospitals as those in other contexts, such as in the United Kingdom. However, a declining interest in a career in bedside nursing has led to a growing concern among nursing leaders that the 'gap' in holistic care functions, such as the provision of essential care duties, will be filled by other, unqualified health providers thus posing a threat to occupational closure.

For almost all the hospital nurses interviewed in this study, remaining in 'bedside' nursing symbolized a stagnant career with limited opportunities for professional advancement and learning. Specialization in clinical areas and entry into advanced practice and management was viewed as prestigious both for individual nurses and for the profession as a whole. Many hospital nurses felt strongly that acquiring greater skill and knowledge in clinical areas could dispel popular images of nurses as doctors' handmaidens and result in greater social standing for members of the profession. The preference found for advanced nursing practice and managerial duties may be a reflection of the collective aim among hospital nurses to achieve greater social desirability. As nurses carve a new mandate for themselves within hospital culture and where tasks traditionally assigned as low status and

⁷⁸ The distribution of nursing tasks to ANMs and unqualified staff tends to be undertaken in private nursing homes that find it considerably more difficult to hire qualified nurses. In most hospitals in Bangalore, essential nursing functions such as observation, feeding, bathing, taking patients to the toilet and so on are predominantly carried out by nurses. In some of the sites, nurses also provided counselling to patients and relatives and provided nutritional guidance. However, there are some signs that this may change in the future particularly in large corporate hospitals that are increasingly hiring allied categories of health workers to take over some of the patient care functions from nurses, such as dieticians, physiotherapists, counsellors and technicians as well as auxiliary categories of health workers (such as ANMs and untrained personnel).

‘impure’ are distributed to auxiliary categories of health staff, nurses are more able to shed the association between nursing and domestic work and achieve a social status closer to that of physicians.

As Amitai Etzioni points out in his work on the semi-professions “*ours is a society where knowledge counts*” (Etzioni 1969: 55), nurses in this study were also acutely aware of the importance of knowledge in establishing themselves as fully fledged professionals and for adapting to the advances in medical practice. As Price has pointed out in her study of professional socialization and career choices in nursing, although nurses did identify with the caring aspect of their profession, they did not want to be solely acknowledged for care work over clinical expertise (Price 2008).

At the same time, therapeutic relationships with patients were found to have a number of functions for nurses in the study. In addition to asserting nursing’s distinctiveness with regard to medicine, nurses viewed their relationships with their patients as providing them with a sense of purpose and job satisfaction. The emphasis on nurse-patient relationships was also found to be tied to efforts to upgrade the image of nursing in hospitals and in wider Indian society. Informal conversations with individuals during this study indicated that hospitals were often evaluated by their nursing care. For example, while talking about certain hospitals, I frequently heard statements such as ‘nurses were friendly and helpful in hospital X’ or alternatively ‘the nursing care was poor at hospital Y’ by former patients or relatives of former patients. In India, as the vast majority of care is paid for out of pocket, private hospitals are in competition with one another for patients. In this sense, emotional labour becomes part of hospital ‘public relations’. Like Hochschild’s Delta Airlines flight attendants, therapeutic relationships with patients (clients) are part of the service itself. The emphasis on adopting a caring, knowledgeable and professional attitude with the public within the hospital (patients, relatives, doctors) was also emphasized by the profession’s leaders as a means to promote a positive image to the public outside the hospital.

Although nurses interviewed across the sites were found to identify strongly with the values and ideals of nursing, particularly the importance of a patient-centred approach to nursing practice, tensions within the profession are particularly evident regarding the future direction of nursing in India. In addition, the portrayal of public/private hospitals as polar cultures of care meant that nurses’ sense of professional identity was also largely influenced by institutional setting. Nurses therefore saw themselves as ‘government nurses’ and ‘private nurses’ and thus part of two different systems of nursing. The study also found that inter-

generational tensions were particularly marked in the narratives of older nurses who depicted younger generations of nurses as those who had replaced the notion of a 'calling' with that of a 'career'. Although 'rhetorics of nostalgia' are to be expected from older generations of nurses who have a strong tendency to refer to the nursing past as a 'golden era', older nurses frequently constituted their professional identity as different to that of younger nurses.

As demonstrated by the study data, the career paths of nurses into nursing education, advanced nursing practice in speciality areas, and the decision to migrate abroad has resulted in a profession that is increasingly diversifying. This study has therefore found that there is a fractured sense of professional identity in India where the notion of professional identity is largely influenced by nurses' career choices and institutional loyalties. Furthermore, the tensions within the narratives around the future of nursing in India indicate the presence of a series of dilemmas at the level of the profession around ways to reaffirm nursing's occupational jurisdiction and maintain occupational closure. At the same time, the study has also found that nurses across the settings share many of the same ideals and values associated with the nursing mandate, namely the importance of adopting a patient-centred approach to nursing practice as well as a collective desire to improve the professional and social status of Indian nurses. Nurses also shared common professional concerns around nursing employment in India, particularly poor pay, long working hours, few career incentives and limited opportunities for further learning. These are consequently areas that can be addressed through human resources policy in individual hospitals and by the Indian government at state and national level.

Moving towards the future

The importance of nursing to the history of women's employment in India cannot be overstated. With the advent of missionary hospitals in India, the need to create a cadre of Indian nurses meant that nursing became one of the few occupations available that offered Indian women, particularly those from socially and economically disadvantaged backgrounds, the possibility of independence and financial security. As seen in the interview narratives of older nurses, nursing has provided a structure through which to reconstruct their lives 'post hoc' where their identity as a 'nurse' emerges as the central thread in their personal biography. These nurses in particular linked their professional lives to personal life events such as marriage, building social networks and opportunities to travel as well as the

opportunity to earn an independent income. As nursing in India establishes itself in the new millennium in a country undergoing important social and economic transformation, the profession is increasingly seeking to move away from local identities characterized by traditional gender and caste assumptions towards a new global identity as internationally mobile, skilled professionals. The opportunities offered by nursing through the potential for employment both in India and overseas have expanded the recruitment base to include those from middle class and high caste families as well as increasing numbers of young men.

At a collective professional level, nursing in India is somewhat at a crossroads- the potential directions of which symbolize key decisions around ways to sustain a core professional identity and to reassert and redefine the profession's occupational mandate and jurisdiction in a changing health system. Unlike countries such as the United Kingdom, Indian hospitals do not have a system of bureaucratized care where hospitals are managed by local government trusts. Although all hospitals in India have to conform to national legislation, private sector hospitals have considerable freedom in the set-up, pricing and organization of their services. The employment of non-nursing personnel as staff in these hospitals presents a challenge to nurses' occupational distinctiveness as traditional nursing tasks are increasingly distributed to auxiliary categories of health workers. In addition, in an era of increasingly educated consumers, many of the nurses in this study were keen to modernize the profession and establish themselves as knowledgeable, skilled professionals with a distinct occupational mandate. Notably, efforts by the Indian Nursing Council to expand the occupational mandate of nursing include the recent creation of the category of Nurse Practitioner in Midwifery where, like in the UK, nurses will be able to take over an increased number of medical functions including the capacity to prescribe medication. As new cohorts of nurse practitioners become visible to the public in carrying out their functions, this may have important implications with regard to wider public perceptions of nursing work.

As discussed in the beginning of this thesis, the study of the professions entails an examination of the changing social environment and context in which occupations seek to establish a collective identity and exert occupational control. This study has therefore examined key influences upon nursing in India, from the effects of gender, caste and class upon membership of the profession to the social and economic incentives increasingly available in an era of globalization. From nursing's expansion in 19th century mission hospitals to the 21st century migration of Indian nurses abroad, nursing acts as a lens through which to examine social change in India. Like their sisters before them, who began to explore

the possibilities of life and work outside India's borders, nurses in India continue to engage with the prospects and potential of their profession as they move towards the future.

Conclusion: some implications for policy

Concerns about gaps in health service provision being generated by shortages in health staff have been raised at various points since the migration of health workers began in earnest in the 1950s and 1960s. However, a renewed emphasis on the health workforce has emerged in recent years with the setting of public health targets, such as the expansion of antiretroviral therapy (ART) for HIV/AIDS and the Millennium Development Goals. This is largely due to a growing recognition that the ability to meet public health goals and improve the health of populations largely depends on the numbers, distribution and skills mix of health staff as well as their quality and effectiveness. The importance attributed to retaining health workers has thus spearheaded a greater focus on addressing issues related to recruitment, retention and motivation. At the same time, given the contextual variations in workforce issues and considerable research gaps, reaching consensus on appropriate strategies to bolster the health workforce has proved challenging.

In almost all countries, nurses make up the largest category of health providers and are key to the success of a range of public health interventions. Nurses are an integral part of human resources for health and as such, concerns related to the recruitment, training and retention of members of the nursing profession are reflected in policy discussions at both national and international level. A particular area of concern continues to be that of international nurse migration as evidenced by a large number of articles, reports and international policy agreements on this topic. Like their counterparts from other countries and regions, Indian nurses are also 'on the move' and eager to take advantage of employment possibilities in high-income countries to secure better economic and career prospects.

As this study has illustrated, the decision to migrate overseas for nursing employment is one aspect of the career trajectories of nurses in India. Concerns regarding shortages of nursing staff in the country are not only related to the movement of nurses outside India's borders, but are also due to a preference among nurses to work in urban areas as opposed to rural postings. Urban centres such as Bangalore offer nurses the possibility to work in large hospital set-ups where they can enter speciality fields, move into nursing education or develop the experience required to seek a nursing position abroad. While considerable attention has been paid to looking at 'push' and 'pull' factors of health workers, few empirical studies have conducted an in-depth qualitative investigation of health workers' career aspirations. Locating decisions regarding migration within the broader career plans and aspirations of nurses can

greatly help to develop a more comprehensive understanding of health worker motivation and facilitate the design of employment policies that may encourage the retention of nurses in their countries of origin.

It is often assumed, for instance, that nurses predominantly migrate for financial reasons. This study found that while financial considerations certainly exerted an influence on the decision to migrate for nurses in the private sector, other reasons were also important to the decision to seek employment overseas. Nurses interviewed in this study frequently complained that opportunities for continued learning are limited in India. Unlike medical personnel, nurses predominantly use the knowledge and skills acquired for their initial qualifications, where these are not updated on a regular basis to reflect advances in nursing and medical practice. The lack of possibilities for on-going learning and upgrading knowledge and clinical skills has thus contributed to a sense of professional frustration and exerts a limiting effect on individual career progression. In addition to economic incentives, migration offers the potential for nurses to 'learn more' through acquiring additional skills and knowledge of clinical practice in resource rich settings. The opportunities offered through placements in the Middle East, North America and Europe were highly valued by nurses in terms of the benefits for nurses' careers as well as the potential to improve the quality of care given to patients. Typically, nurses who had worked abroad were able to secure higher positions in hospitals or in nursing education in a relatively shorter period than those nurses who had elected to stay in India. Some return migrants also described how they incorporated their experience of nursing practice in other countries into training for hospital nurses and nursing students upon their return to India.

In international public health forums and in the media, the out-migration of nurses is frequently depicted as a 'brain drain'. While the concerns raised by the migration of doctors and nurses from settings where they are greatly needed are justifiable, the findings of this study has led me to reassess more carefully the implications of migration for health services and for the profession of nursing more specifically. Although it is certainly the case that the permanent migration overseas of health workers from resource constrained countries does present the potential for a critical loss of essential knowledge and skills, return migration is also an important trend that has hitherto received little attention. Here, an argument can be presented that emphasizes the contribution of skills and knowledge brought *back* to the country of origin of nurse migrants. These experiences may include learning additional skills in patient care and in the use of new technology. This study supports the notion that migratory

paths for Indian nurses are not linear and permanent, but rather may involve multiple trajectories back and forth between India and other countries. The study found that the vast majority of nurses interviewed expressed their desire to return to India after working for a period abroad. Rather than representing a permanent loss of nursing skills to the country, nurse migration from India also presents the opportunity for acquiring additional knowledge and experience obtained through exposure to nursing practice in different settings. Nurses who work overseas may also create cross-cultural networks and continue to maintain relationships with former colleagues, thus bolstering professional ties across borders.

In addition, as discussed in this thesis, migration offers women the possibility for social mobility through better marriage prospects and the ability to save for marriage expenses. Savings and remittances from abroad also enable nurses to support family businesses, purchase property 'back home' and thus achieve greater economic independence. Therefore, as Catherine Choy has pointed out in her study of Filipino nurses, a 'nurse's cap' symbolizes a passport to a life abroad (Choy 2003), but it is also a means through which to secure greater life opportunities in India. Nurse migration is thus a visible example of female mobility that is important to elevating the status of women as well as to raising the profile of this female dominated profession. As such, migration is a significant social and professional strategy for nurses at both an individual and collective level.

Interviews with hospital managers and nursing supervisors in Bangalore indicate that the loss of nurses is most keenly felt in the gap in 'middle management' (i.e. nurses with more than 5 years of experience). Upon finishing an obligatory period in the hospital and satisfying the requirement for a minimum number of years of work experience, young nurses frequently demonstrate their desire to work abroad thus creating a high turn over of staff that would ordinarily fill 'middle management' positions. This has presented an important challenge to the organization of nursing care in many of Bangalore's hospitals but has also emerged as a constraint in finding instructors for the city's nursing schools and colleges. While nurses from some regions in India, such as Kerala, have strong ties to networks overseas and this exerts an additional incentive to travel abroad, for other Indian nurses who are mainly motivated by the prospects of better financial and career opportunities, efforts can be made to improve their prospects within the country. It is to these potential strategies to encourage retention that we turn our attention below.

The attrition of nurses either through migration or leaving the profession altogether is strongly linked to the relatively low professional status given to nursing in India. Although

the social and professional status of nurses is beginning to change, to attract more nurses into the profession who are willing to work in the country, it is important that efforts be made to elevate the social status of nurses through promoting greater professional visibility. Although nurses do receive media attention on International Nurses' Day, regular features on nurses in the mainstream Indian media may be helpful towards shifting the Indian mindset that tends to view nurses as a 'pair of hands' engaged in 'dirty' or undesirable work towards an image of nurses as modern health professionals. The visibility of nurses can also be encouraged through setting up health promotion events in local communities where nurses offer counselling and advice on a variety of locally relevant health issues. Such events have a strong capacity building component for nurses themselves and mirror the rural posting training that they receive during their studies. Community events run by nurses can also serve an important public health function and encourage a greater link between the health sector and the public. As public concerns over the quality of nursing educational institutions have served to undermine confidence in the profession more broadly, the accreditation of all nursing educational institutions must be carried out to secure public trust.

The study findings also point towards the potential for nurses to take on a greater scope of work that includes more autonomous duties. While power relations have historically governed the boundary between nursing and medicine, it is clear that in practice these boundaries are flexible with many nurses informally taking on a range of routine medical tasks. Consequently, the nursing mandate could be expanded or revised to include a formal acknowledgement of the clinical and managerial roles that characterize contemporary nursing practice. India, like many other countries, has an inequitable distribution of health workers and consequently the potential for 'task shifting' between physicians, nurses and other categories of health staff needs to be explored through, for example, developing more autonomous roles for nurses. The creation of an independent nurse practitioner in Midwifery to provide obstetric care particularly in underserved, rural areas is an important step in this direction and schemes that promote greater professional authority for nurses may encourage their willingness to work in rural health facilities.

In order to address the professional stagnancy experienced by nurses particularly in hospital settings, a long term approach to learning should be encouraged by nursing management and integrated into staff development plans. This can include seminars on new developments in medicine and nursing, interactive in-service training and workshops. Training programmes for nurses should also include leadership and management skills to

enable nurses to participate more actively in the planning and organization of health services at national and district level.

Management deficiencies in terms of inadequate supervision and feedback, limited career progression and/or wage increases can lead to staff feeling underappreciated and under valued, thus contributing to low morale and motivation. Hospital and nursing management can address these issues by providing regular feedback to staff and through providing performance related incentives. These do not have to always be financial. For example, selected nurses who have performed well can be supported to attend conferences or workshops, receive certificates of appreciation or other forms of recognition. Nursing staff that have participated in nursing events can be encouraged to give presentations on their experience to their colleagues and act as role models to nursing students and junior nurses.

In many countries, nurses are paid minimum wages or receive salaries equivalent to low skilled workers. Nursing salaries in India are low and this issue needs to be addressed particularly in the private health sector in which salaries are set by the institutions themselves and vary considerably. Some nurses receive equivalent salaries to taxi drivers, factory workers and maids, thus compounding the image of nursing as an unskilled occupation that has relatively low social prestige. The implementation of a nation-wide salary guideline for health workers may be one way to address the vast discrepancy in salaries particularly in privately run institutions. Nation-wide salary increases across the public and private sectors constitute another approach, but this is not always possible due to fiscal restraints and the need to be gradual in order to be sustainable. Research has shown that it is not necessary to 'match' salaries that would be earned in developed countries as this would be unrealistic. Rather, some studies have illustrated that even small wage increases so that nurses can make a living have been shown to be effective in retaining nursing staff (ICN 2006; Kingma 2006). Other financial incentives include bonus payments, pension, insurance, allowances, loans, payment of tuition for further education and payment for hours worked overtime (ICN 2006; Buchan and Dovlo 2004).

The landscape of global public health is continually shifting, partly as a result of the social and economic changes brought about by globalization and through important changes in medical science and technology. Meeting new public health needs as they emerge often requires rethinking the organization and delivery of health services, including the roles and functions of health workers. At the same time, strengthening human resources for health (HRH) is a long-term process requiring sustainable strategies and approaches. These need to

be based upon a strong and comprehensive research base, not just on the scale of health worker shortages but also on appropriate responses through increased research on interventions. More efforts appear to be concentrated on quantifying the problem, with less information available on its qualitative aspects through in-depth examination of the work and career goals of health workers. This thesis therefore aimed to address this research gap by capturing the motivations and incentives behind nursing careers in an urban context in India through the narratives of both the men and women now engaged in the profession. In doing so, the study revealed a number of professional dilemmas that are shared among members of the nursing profession across countries and coalesce particularly around working conditions, pay and professional authority. What has also emerged clearly in the study's findings is that these professional dilemmas are intricately bound to the career aspirations and motivations of nurses and as such, demonstrate the importance of addressing career motivations and choices as a fundamental component of human resource policy and programming.

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Appendices

Appendix 1

Table 1 : 'Home state' of nurses across the sites

State	Site 1 (private hospital)	Site 2 (private hospital)	Site 3 (private mission hospital)	Site 4 (private outpatient clinic)	Site 5 (government hospital)	Site 6 (government hospital)
Andhra Pradesh	1					
Karnataka	5	10	2		6	8
Kerala	5	4	3	3		
Tamil Nadu					4	
Total	11	14	5	3	10	8

Appendix 2

Table 2 : Religion and caste

Religion	Number of nurses
Christian	26
Hindu	29
Nagarathar	1
Naidu	2
Nair	2
Lingayat	2
Panicker	1
Scheduled Caste (SC)	6
Scheduled Tribe (ST)	2
Vokkaliga	2
Vokkaliga Gowda	8
No caste data	3
Muslim	1
Total	56

Appendix 3

Table 3 : Age distribution by site

Age bracket	Site 1 (private hospital)	Site 2 (private hospital)	Site 3 (private mission hospital)	Site 4 (private outpatient clinic)	Site 5 (government hospital)	Site 6 (government hospital)
20-25	7	4				
26- 30	1	4	1	2		
30- 35	1	1	1	1	4	2
36- 40	1	1			2	1
40- 45		1	1		1	2
46- 50						
50- 55					1	2
56- 60	1	3	1		2	1
No data			1			
Total	11	14	5	3	10	8

Appendix 4

Table 4 : Nursing qualifications

Type of Degree	Site 1 (private hospital)	Site 2 (private hospital)	Site 3 (private mission hospital)	Site 4 (private outpatient clinic)	Site 5 (govt hospital)	Site 6 (govt hospital)	Site 7 Nursing colleges
GNM only	8	14	4	3	1	6	
BSc only	2				3	1	
GNM plus 'post-basic/certificate'	1				1	1	
MSc/MA			1		2		
MPhil/PhD							3
GNM 'plus' Specialized Diploma					3		
Total number of nurses interviewed per site	11	14	5	3	10	8	3

Appendix 5

Table 5 : Nursing colleges in Karnataka 1998-1999, 2003-2004

Districts	1998-1999			2003-2004		
	Govt	Private	Total	Govt	Private	Total
1.Bagalkot	0	1	1	0	1	1
2.Bangalore Rural	0	0	0	0	2	2
3.Bangalore Urban	1	16	17	1	83	84
4.Belgaum	0	1	1	0	2	2
5.Bellary	0	1	1	0	3	3
6.Bidar	0	3	3	0	2	2
7.Bijapur	0	1	1	0	2	2
8.Chamarajnagar	0	0	0	0	0	0
9.Chikkamgular	0	0	0	0	0	0
10.Chitradurga	0	1	1	0	4	4
11.Dakshina Kannada	0	7	7	0	13	13
12. Davangere	0	1	1	0	2	2
13. Dharwad	0	0	0	0	3	3
14. Gadag	0	0	0	0	0	0
15. Gulbarga	0	2	2	0	2	2
16. Hassan	0	2	2	0	4	4
17. Haveri	0	0	0	0	0	0
18. Kodagu	0	0	0	0	0	0
19. Kolar	0	3	3	0	3	3
20. Koppal	0	0	0	0	0	0
21. Mandya	0	1	1	0	1	1
22. Mysore	0	1	1	0	4	4
23. Raichur	0	1	1	0	1	1
24. Shimoga	0	1	1	0	3	3
25. Tumkur	0	3	3	0	7	7
26. Udupi	0	1	1	0	1	1
27. Uttara Kannada	0	0	0	0	1	1
Karnataka	1	47	48	1	144	145

(Source: Government of Karnataka 2006)

Appendix 6: Information sheet for in-depth interviews

Study on work and career among Indian nurses

Information sheet (In-depth interviews)



London School of Hygiene and Tropical Medicine

Introduction

Hello, my name is Sonali Johnson and I am a PhD student in the Department of Public Health and Policy at the London School of Hygiene and Tropical Medicine. My research study is about the work and career of nurses in India.

The following document explains the purpose of the study and what will be involved if you decide to participate. My contact details are given at the end of the information sheet and you are welcome to contact me at any time for further questions or comments.

Why do this research?

Research on health workers is very important to understand public health systems. Nurses are a cornerstone of public health services worldwide and therefore, research on nurses is critical. However, there are a number of research gaps in knowledge around nursing culture and practice, especially in countries outside Europe and North America. For example, there are very few in-depth studies on the reasons behind work and career choices of nurses that are based on interviews and discussions with nurses. These types of studies are important to better understand the issues faced by nurses, as well as their work and career goals.

There is very little information on the work and career plans of Indian nurses or on understandings of contemporary nursing culture in India. This information is important as it can contribute to knowledge on the sociology of nursing in India. It can also help design more responsive human resources policies for nurses. For these reasons, you are being requested to participate in this study.

What does the study aim to do?

At a broad level, the study aims to understand how nurses in India see their work and career choices. It will look at why nurses chose to enter the nursing profession, well as their career plans and goals, including attitudes towards migration.

What are the procedures?

I would like to invite your participation in an **in-depth interview**. The interview will last for approximately one hour and will be recorded. The questions that I will ask you will relate to the research objectives outlined above. The contents of the discussion will be confidential, transcribed by myself and a research assistant. These recordings will only be seen by me, a research assistant and my research supervisor. There will be no names attached to the recordings, only a code. The key for the codes will only

be seen by me. The interviews will be undertaken on-site in a private room or, if you prefer, at another location that is convenient for you. If you agree to be interviewed, you will be asked to give your consent on the tape.

Are there any risks?

There are very few risks to participating in this study, as the research is not on a 'sensitive' topic as such. The discussion will be more on general issues around career choices in nursing rather than employment issues relating to a particular health institution. However, all opinions and information that you express during the interview will be kept confidential and anonymous. Participation in the study is entirely voluntary and withdrawal is possible at any time. You do not have to give a reason. There will be no consequences to you if you do decide to take part in this research, or if you do not want to take part. Once the study has been completed and the thesis finalized, the recording will be erased.

Are there any benefits to participating?

There will be no direct, individual benefit to you if you decide to participate in this research. However, the research will be beneficial to nurses more broadly as it can increase understanding of the sociology of nursing in India and can assist in laying the ground work for human resources policies for nurses. You will not receive any payment, except to reimburse your transportation costs if you would like the interview to be held at place away from where you work.

Ethical Approval

The study has been approved by the Ethics Committee of the London School of Hygiene and Tropical Medicine

Local contact details

You can contact me at anytime at the following telephone numbers and email address: Home- 080 2845-6015, Mob- 9886747994

Email: sonali.johnson@lshtm.ac.uk

If you have any further questions or comments, you can contact my PhD supervisor, Dr Judith Green at Email: judith.green@lshtm.ac.uk

Appendix 7: Consent form



Consent Form

Study on work and career among Indian nurses

Name of Primary Investigator Sonali Johnson, MSc
PhD Candidate
Department of Public Health and Policy,
London School of Hygiene and Tropical Medicine,
Keppel Street, London WC1E 7HT
United Kingdom

Contact Details in Bangalore Tel home: (080) 2845-2364
Mobile: *to be inserted*
Email : sonali.johnson@lshtm.ac.uk

I have read the information sheet concerning this study and I understand what will be required of me in participating in this research. My questions concerning this study have been answered satisfactorily by Sonali Johnson. My participation in this research is voluntary and I understand that at any time I may withdraw from this study without giving a reason and without affecting my status at my institution in any way.

I agree to take part in this study.

Signed.....

Date.....

Signature of PI.....

Date.....

Appendix 8: Ethics clearance

**LONDON SCHOOL OF HYGIENE
& TROPICAL MEDICINE**

ETHICS COMMITTEE



APPROVAL FORM

Application number: 5126

Name of Principal Investigator Sonali Johnson
Department Public Health and Policy
Head of Department Professor Anne Mills

Title: Shifting conceptions of work and career among Indian nurses.

This application is approved by the Ethics Committee.

Chair
Professor Tom Meade

Date 21 May 2007

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the consent form must be re-submitted to the Committee.

Appendix 9: Table of Participants (pseudonyms)

Name	Sex	Age	Home state	Religion (caste where known)	Qualifications	Site
Aakesh	Male	38	Karnataka	Hindu	BSc	5
Aarushi	Female	25	Karnataka	Hindu (Gowda)	GNM	2
Aishwarya	Female	24	Kerala	Christian	GNM	2
Ajit	Male	23	Karnataka	Hindu (Gowda)	GNM	2
Annie	Female	32	Kerala	Christian	GNM	1
Asha	Female	44	Karnataka	Christian	GNM Post-basic BSc	6
Ashwani	Female	23	Kerala	Christian	GNM	1
Bhaagya	Female	32	Karnataka	Hindu (gowda)	GNM	6
Bhavna	Female	29	Karnataka	Hindu (gowda)	GNM	2
Deepa	Female	30	Tamil Nadu	Christian	GNM	5

					Post-basic BSc	
Deidre	Female	44	Karnataka	Christian	BSc, MSc, PhD candidate	Nursing College
Devi	Female	57	Kerala	Hindu (SC)	GNM	2
Eileen	Female	n/d	Kerala	Christian	BSc, MSc	3
Gauri	Female	31	Karnataka	Hindu (Vokkaliga)	GNM	2
Geeta	Female	59	Tamil Nadu	Christian	GNM Diploma Psychiatric Nursing	5
Grace	Female	36	Karnataka	Christian	GNM	5
Jasmine	Female	36	Karnataka	Hindu (Gowda)	BSc	6
Josephine	Female	37	Karnataka	Christian	GNM Post-basic BSc	1
Joy	Female	47	Karnataka	Christian	GNM	Other
Kamla	Female	57	Karnataka	Hindu (SC)	GNM	6

Kanak	Male	29	Karnataka	Hindu (Kuruba)	GNM	2
Karishma	Female	54	Karnataka	Hindu (Lingayat)	GNM	6
Karthik	Male	34	Kerala	Christian	GNM	4
Kaveri	Female	60	Karnataka	Hindu (Panicker)	GNM	2
Kumari	Female	24	Karnataka	Hindu (Naidu)	BSc	1
Laila	Female	31	Kerala	Christian	GNM	3
Lakshmi	Female	52	Karnataka	Hindu	GNM Diploma in Psychiatric Nursing	5
Lily	Female	39	Kerala	Christian	BSc, MSc	2
Lizzy	Female	27	Karnataka	Christian	GNM	1
Malika	Female	25	Kerala	Christian	GNM	1
Manjula	Female	24	Karnataka	Hindu (Kuruba)	GNM	2

Meena	Female	59	Karnataka	Christian	GNM	3
Miriam	Female	43	Kerala	Christian	GNM	3
Nandini	Female	42	Karnataka	Hindu (SC)	GNM	6
Neelam	Female	53	Karnataka	Christian	GNM	6
Parvati	Female	34	Karnataka	Hindu (SC)	BSc, MSc	5
Prabha	Female	25	Karnataka	Hindu (Naidu)	BSc	1
Professor Nande	Male	55	Karnataka	Hindu (Gowda)	GNM, post- basic BSc, Diploma in psychiatric nursing, MSc PhD candidate	Nursing College
Rani	Female	28	Karnataka	Hindu (Lingayat)	GNM	2
Rita	Female	29	Kerala	Christian	GNM	4
Rose	Female	45	Tamil	Christian	GNM, post-	5

			Nadu		basic BSc, Diploma Nursing Administration	
Santosh	Male	25	Kerala	Christian	GNM	1
Sarita	Female	37	Karnataka	Hindu (SC)	BSc, MSc	5
Saroj	Female	33	Karnataka	Christian	Post-basic BSc	6
Savitri	Female	57	Andhra Pradesh	Hindu	GNM	1
Shalini	Female	29	Kerala	Hindu (Nair)	GNM	4
Shoba	Female	29	Karnataka	Hindu (Vokkaliga)	GNM	2
Sonya	Female	58	Tamil Nadu	Hindu (Nagaratha)	BSc	5
Sophie	Female	80	Karnataka	Christian	GNM	Other
Soraya	Female	22	Karnataka	Muslim	GNM	1
Suzanne	Female	33	Kerala	Christian	BSc, MSc	Nursing College
Tara	Female	28	Karnataka	Hindu (Gowda)	GNM	3

Thomas	Male	24	Kerala	Christian	GNM	1
Uma	Female	29	Karnataka	Hindu (Gowda)	GNM	2
Vandana	Female	58	Kerala	Hindu (Nair)	GNM	2
Veena	Female	33	Karnataka	Hindu (SC)	BSc	5

Appendix 10: 'Batch-mates'



